TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision
General Information

Requestor Name
GABRIEL JASSO PHD

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-22-0899-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
January 13, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2021 through March 8, 2021	97799 Interdisciplinary Traumatic Brain Injury Program	$9,000.00	$9,000.00
	Total	$9,000.00	$9,000.00

Requestor's Positions

"Our office received an explanation of review for date of services: 3/1/2021-3/08/2021for (claimant). First EOB came back on 09/29/2021 with payment amount of $5,000 ($1,000 per date). However, our office was paid for the second half of the program correctly ($2,800) I have provided a copy of the second half of the sessions being paid correctly. All medical records/ notes submitted support the services provided for the traumatic brain injury program."

Supplemental Position Submitted February 1, 2022:

"I have included the following to justify that the payment amount being sought is fair…

Supplemental Position Submitted February 4, 2022:

"If the treating doctor…and neuropsychologist… felt the appropriate treatment for this client would have been chronic pain management program then the program would have been requested under "chronic pain management program" however, both treating doctor and requestor deemed the appropriate treatment is Traumatic Brain Injury Program

Amount in Dispute: $9,000.00

Respondent's Position

"The CPT code 97799 was reimbursed pursuant to the applicable Medicare base rate and Division modifier at $125 per hour….The Carrier contends the Provider is not entitled to additional reimbursement"

Initial Response Submitted by: Travelers

"Consistent with Rule 134.1, the Carrier based the reimbursement rate for CPT code 97799 billed for a brain injury program on the reimbursement rate for CPT code 97799-CP. The brain injury program and the chronic pain management program consume similar resources and provide similar services in an outpatient setting. The rate of $125/hr. is the Division adopted fee schedule Maximum Allowable Reimbursement for CPT code 97799-CP."

Supplemental Response Submitted by: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the fee guideline for return-to-work rehabilitation programs.
3. 28 TAC §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
- W3 – Additional payment made on appeal/reconsideration.
- 8774 – Services performed have been identified as a Brain Injury Specialty Program based submitted documentation. Reimbursement was made per Texas Interdisciplinary Rehabilitation Program guidelines.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 947 – Upheld. No additional allowance has been recommended.

Issues

1. Has the requestor justified that the payment amount sought is a fair and reasonable rate of reimbursement?
2. Has the respondent justified that the payment made is a fair and reasonable rate of reimbursement?
3. Is the requestor entitled to additional reimbursement for an Interdisciplinary Traumatic Brain Injury Program rendered from March 1, 2021 through March 8, 2021?

Findings

1. The requestor seeks an additional reimbursement in the amount of $9,000.00 for a Brain Injury Rehab services rendered from March 1, 2021 through March 8, 2021.

   On January 19, 2021, the respondent gave preauthorization approval for Brain Injury Rehab program, 40 hrs., 97799 x 80, interdisciplinary rehab programs (TBI) 97799.

   The requestor billed for the Brain Injury Rehab program with CPT code 97799. CPT Code 97799 is defined as "Unlisted physical medicine/rehabilitation service or procedure."

   In the insurance carrier's original position statement, they state "CPT Code 97799 was reimbursed pursuant to the applicable Medicare base rate and Division modifier at $125 per hour...The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement rate of $125 per hour is correct as calculated." The $125 per hour rate is taken from 28 TAC §134.230(5)(B) which sets out reimbursements for Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. The dispute involves reimbursement for a traumatic brain injury rehabilitation program not covered under 28 TAC §134.230.

   To determine if the disputed services are eligible for reimbursement the DWC refers to the following statute and rules:

   - TLC §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
   - 28 TAC §134.1(e)(3) states, "Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."
   - 28 TAC §134.1(f) states, "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
   - 28 TAC §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds that:

- The requestor seeks reimbursement for the full amount of the billed charges because "A fee schedule has not yet been determined for this type of treatment."
- The respondent issued a payment of $1,000.00 for each disputed date of service.
- The DWC has not established a fee guideline for Brain Injury Rehab Programs.
- The requestor submitted a redacted copy of EOB from the same insurance carrier for the same claimant that supports payment of $2,800.00.
- The requestor submitted copies of previous MFDR decisions to support payment of $2,800.00.
- The DWC finds that $2800.00 is a fair and reasonable reimbursement.
- The DWC finds the requested amount to be consistent with TLC §413.011(d).

2. Because the requestor has met the burden to show that the amount sought is a fair and reasonable rate of reimbursement, the Division now reviews the information presented by the respondent to support whether the amount paid is a fair and reasonable rate of reimbursement for the disputed services.

   28 TAC §133.307(d)(2)(E)(v), requires the respondent to provide:

   > documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable.

   Review of the submitted documentation finds:

   - The respondent states: "The rate of $125/hr. is the Division adopted fee schedule Maximum Allowable Reimbursement for CPT code 97799-CP."
   - The respondent did not explain or present sufficient documentation to support how the payments were based on the Texas Fee Guidelines or Texas Department of Insurance Division of Workers' Compensation Acts and Rules.
   - As stated above, the Division has not established a fee schedule or fee guideline applicable to brain injury rehab program; reimbursement shall therefore be made in accordance with a fair and reasonable reimbursement amount as specified in 28 TAC §134.1(f).
   - Per 28 TAC §134.1(g), "The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts." The respondent did not explain or submit sufficient documentation to support the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts for the disputed services in accordance with the requirements of §134.1(g).
   - The respondent did not support that the amount paid satisfies the requirements of §134.1(f).
   - The respondent did not support that the amount paid represents a fair and reasonable reimbursement for the services in dispute.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 TAC §133.307(d)(2)(E)(v).

3. The requestor supported that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The requestor met its burden to prove that the amount of payment it seeks from the insurance carrier is fair and reasonable. Consequently, the requestor's request for reimbursement of $9,000.00 is recommended.

The DWC finds the requester has established that reimbursement of $9,000.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $9,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 1, 2022
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.