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

General Information

Requestor Name
NORTH TEXAS
REHABILITATION CENTER

Respondent Name
COMAL ISD

MFDR Tracking Number
M4-23-0140-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
September 15, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 6, 2022 through June 22, 2022	97799-CA Brain Injury Program	$30,800.00	$23,870.00
	Total	$30,800.00	$23,870.00

Requestor's Position

"We billed 97799-CA, an unlisted procedure code, for a service not yet established by the state of Texas. We have listed out our description of a 'Brain Injury Program' and a copy of the ODG Guidelines. You will notice a copy of the authorization approval given by Review Med Utilization Department and the procedures being 'Medically Necessary' based on the Compensable Injury... According to the Guideline of ODG, we are to put any patient with this type of injury in a 'Brain Injury Program... The services we are providing, a Brain Injury Program has not yet been established and according to the TDI Guidelines, (§134.203. Medical Fee Guideline for Professional Services) if a fee schedule is not yet established, there is not a Medicare or Medicaid fee schedule and you have not come to a negotiated fee schedule you have to come to a Fair and Reasonable rate."

Amount in Dispute: $30,800.00

Respondent's Position

"The services in question were for a CARF accredited Return to Work Program. The provider initially filed charges as CPT code 97799-CA and although we requested the provider refile with the appropriate modifier, they refused to do so stating the services being rendered had no fee schedule. Based on Texas Administrative Code Title 28, Chapter 134, Subchapter C Rule 134.204 (n), (4), the correct modifier would be MR. Rule 134.204 (h) (4) (A) (B) allows $90.00 per hour. As the provider refuses to file the charges with the appropriate modifier CAS applied the $90.00 per hour for 1 hour (the provider only billed 1 unit on the CMS-1500 form). After a reconsideration, based on Preauthorization CAS allowed for the full 8 hour per session for a total payment of $720.00 per session. The provider is insisting on payment in full. It is our position that payment issued was correct and no additional reimbursement would be due."

Response Submitted by: Claims Administrative Services, Inc.

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 §134.1 sets out the fair and reasonable reimbursement guidelines in the absence of an applicable fee guideline.
3. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines
4. 28 TAC §134.230 sets out guidelines for Return-to-Work Rehabilitation Program.

Denial Reasons

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

- P12-WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- W3-IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 350-BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 790-THIS CHARGE WAS REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. Did the insurance carrier issue a payment for the disputed services?
2. What rules apply to the reimbursement of an Interdisciplinary Traumatic Brain program?
3. Is the requestor's request for additional reimbursement supported?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The requestor seeks reimbursement for a preauthorized Interdisciplinary Traumatic Brain Injury Program rendered on June 6, 2022 through June 22, 2022.

   The insurance carrier indicates that a payment was issued for the services in dispute according to Rule §134.230 (4)(A-B), and therefore the requestor is not entitled to an additional payment for dates of service June 6, 2022 through June 22, 2022.

   The following dates of service were partially paid by the carrier;

Date of Service	CPT Code	Amount Billed	Amount Paid	Amount recommended/ Amount Deducted	Total Amount Paid	Amount Due
June 6, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 7, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 8, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 9, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 10, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 13, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 15, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 17, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 20, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 21, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
June 22, 2022	97799-CA	$2,800.00	$90.00	$720 – $-90.00	$630.00	$2,170.00
TOTAL		$30,800.00	$990.00	$6,930.00	$6,930.00	$23,870.00

2. The DWC finds that a medical fee guideline for an Interdisciplinary Traumatic Brain Injury Program has not been established. Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment is therefore subject to the general medical reimbursement provisions of 28 TAC §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   The requestor billed CPT code 97799-CA, for an Interdisciplinary Traumatic Brain Injury Program. CPT Code 97799 is defined as "Unlisted physical medicine/rehabilitation service or procedure." The requestor appended modifier "CA" to identify that the services are CARF accredited.

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

- 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 §134.230 states, "The following shall be applied to Return-to-Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier."
- 28 TAC §134.230 states, "(1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).
- 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."

3. Review of the submitted documentation finds the following:
    - The requestor seeks reimbursement for the full amount of the billed charges because "if a fee schedule is not yet established, there is not a Medicare or Medicaid fee schedule and you have not come to a negotiated fee schedule you have to come to a Fair and Reasonable rate."
    - The requestor seeks reimbursement in the amount of $30,800.00 for disputed dates of service June 6, 2022 through July 21, 2022.
    - The respondent issued payments totaling $6,930.00 after the submission of medical fee dispute.
    - The disputed amount is $30,800.00 minus $6,900.00 equals the amount sought of $23,870.00.
    - The DWC has not established a fee guideline for Traumatic Brain Injury Programs.
    - The requestor submitted redacted copies of EOBs from several different insurance carriers that support payments ranging from $2,240.00 to $2,800.00.
    - The DWC finds that most insurance carriers found $2,800.00 to be fair and reasonable reimbursement.
    - The DWC finds the requested amount to be consistent with TLC §413.011(d).
    - The requestor supported that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.
4. The DWC finds that the requestor sufficiently supported the fact that additional reimbursement in the amount of $23,870.00 is due. As a result, this amount is recommended.

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 DWC finds the requester has established that reimbursement of $23,870.00 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 $23,870.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 16, 2023
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.