Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

North Texas Rehabilitation Center

Respondent Name

Ace American Insurance Company

MFDR Tracking Number

M4-23-0386-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

October 13, 2022

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 24, 2022	97799-CA Traumatic Brian Injury Services	$2,800.00	$0.00
January 25, 2022	97799-CA	$2800.00	$0.00
January 26, 2022	97799-CA	$2800.00	$0.00
January 27, 2022	97799-CA	$2800.00	$0.00
January 28, 2022	97799-CA	$2800.00	$0.00
February 28, 2022	97799-CA	$2800.00	$0.00
March 1, 2022	97799-CA	$2800.00	$0.00
March 3, 2022	97799-CA	$2800.00	$0.00
March 4, 2022	97799-CA	$2800.00	$0.00
March 7, 2022	97799-CA	$2800.00	$0.00

March 8, 2022	97799-CA	$2800.00	$0.00
March 9, 2022	97799-CA	$2800.00	$0.00
March 10, 2022	97799-CA	$2800.00	$0.00
March 11, 2022	97799-CA	$2800.00	$0.00
March 14, 2022	97799-CA	$2800.00	$0.00
March 15, 2022	97799-CA	$2800.00	$0.00
March 17, 2022	97799-CA	$2800.00	$0.00
March 18, 2022	97799-CA	$2800.00	$0.00
March 21, 2022	97799-CA	$2800.00	$0.00
March 23, 2022	97799-CA	$2800.00	$0.00
March 25, 2022	97799-CA	$2800.00	$0.00
March 28, 2022	97799-CA	$2800.00	$0.00
March 30, 2022	97799-CA	$2800.00	$0.00
March 31, 2022	97799-CA	$2800.00	$0.00
April 1, 2022	97799-CA	$2800.00	$0.00
	Total	$56,000 ($70,000)	$0.00

Requester's Position

"You will notice a copy of the authorization approval given by Genex 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".

Supplemental Position Statement: " The TBI program has demonstrated positive outcomes for [injured employee], with significant improvements in his cognitive, physical, and emotional functioning. These outcomes support the effectiveness of the program and warrant the reimbursement rate being sought. . . It is also important to note that for the past seven years, the insurance company, ESIS, has consistently paid the requested rate for our services, as evidenced by over 100 dates of service that we have on record. This longstanding payment history demonstrates

that the insurance company has recognized the value and appropriateness of our fee structure, further supporting our assertion that the payment amount being sought is fair and reasonable".

Amount In Dispute: $56,000.00

Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above-mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0. Bill did not include all appropriate Modifiers and was billed for only 1 unit per day".

Response Submitted By: ESIS

Findings and Decision

Authority

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

Statutes and Rules

1. TLC §413.011 sets out general reimbursement policies and treatment guidelines and protocols.
2. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.
3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 TAC §134.1 sets out medical reimbursement policies.
5. 28 TAC §134.230 sets out the return-to-work rehabilitation programs.

Adjustment Reasons

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

1. 1, 6 – Previous gross recommended payment amounts online: $0.00
2. 1, 2 – The appropriate modifier was not utilized.
3. 193 – Original payment decision is being maintained. This claim was processed properly the first time.
4. 2, 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
5. 5 – This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this

time.

6. 7, W3 – TDI Level appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19.
7. 1 – Time indicated on report; Brain injury specialty program previous gross recommended payment amounts online; $0.
8. 2 – This procedure on this date was previously reviewed.
9. 18 – Duplicate claim/service.
10. 1 – Please resubmit with a more appropriate CPT/HCPCS codes that better reflects services documented.
11. 2, 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
12. CO – Contractual obligations. The patient may not be billed for this amount.
13. W1 – Workers' compensation jurisdictional fee schedule adjustment.
14. 1 – Brain injury specialty program.
15. 4 – A technical bill review has been performed.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the reimbursement of CPT code 97799?
3. Did the requester submit sufficient documentation to support the fair and reasonable reimbursement rate of $2,800?
4. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester is seeking reimbursement in the amount of $56,000.00, as reflected in the table of disputed services. However, the correct total amount is $70,000.00. The $56,000.00 figure appears to be a typographical error. Accordingly, DWC will review the correct total disputed amount of $70,000.00.

   This dispute concerns a preauthorized Interdisciplinary Traumatic Brain Injury (TBI) Program provided from January 21, 2022, through April 1, 2022. The services at issue were billed under CPT code 97799-CA, with the "CA" modifier indicating that the program is CARF-accredited. The insurance carrier denied the disputed services with the denial reduction codes indicated above.

2. This dispute pertains to the non-payment of a traumatic brain injury program that took place between January 21, 2022, and April 1, 2022.

28 TAC Section 134.1 outlines the reimbursement requirements for medical services.

Under 28 TAC §134.1(e), healthcare services provided outside of a workers' compensation healthcare network must be reimbursed in accordance with one of the following:

- Division fee guidelines.
- A negotiated contract; or
- A fair and reasonable reimbursement amount under subsection (f), when neither of the above apply.

CPT Code 97799 is not addressed by the Division's fee guidelines, and neither party submitted documentation establishing a negotiated contract. Accordingly, the disputed service must be reimbursed based on a fair and reasonable amount pursuant to 28 TAC §134.1(f).

28 TAC Section 134.1(f) defines fair and reasonable reimbursement as a rate that:

- Complies with Labor Code Section 413.011 criteria.
- Ensures similar procedures in similar circumstances receive similar reimbursement; **and**
- It is based on nationally recognized published studies, Division medical dispute decisions, and/or valuations for comparable services.

Labor Code Section 413.011 mandates that fee guidelines be:

- Fair and reasonable,
- Promote quality care and cost control,
- Encourage timely return to work, and
- Avoid excessive payments compared to similar care for individuals with comparable standards of living.

28 TAC Section 133.307 requires the requester 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 Section 134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

28 TAC Section 133.307 requires a position statement of the disputed issue(s) that should include:

(i) the requester's reasoning for why the disputed fees should be paid or refunded,

(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

(iii) how the submitted documentation supports the requester's position for each disputed fee issue.

3. As previously stated, reimbursement of CPT Code 97799 is determined in accordance with 28 TAC Section 134.1(f) and Texas Labor Code Section 413.011, which require that payment be based on a "fair and reasonable" standard.

   In support of the requested reimbursement rate of $2,800 per day, the requester submitted the following documentation:

   1. Explanation of Benefits (EOBs) from various insurance carriers, which show payments ranging between $2,240 and $2,260. Additionally, there is one EOB reflecting a payment of the sought amount of $2800.
   2. One (1) Medical Fee Dispute Resolution (MFDR) decision referencing CPT code 97799 to support the higher payment rate.

   Because no Division fee guideline or negotiated contract applies, the disputed services must be evaluated under the statutory and regulatory criteria for fair and reasonable reimbursement.

   After a review of the submitted documentation and applicable standards, DWC finds that the requested reimbursement rate of $2,800 per day is not supported for the following reasons.

   The requester did not provide documentation demonstrating that the billed charges for the disputed services reflect a fair and reasonable reimbursement rate as required under 28 TAC Section 134.1 and Labor Code Section 413.011.

   A health care provider's "usual and customary" charges, standing alone, do not constitute evidence of a fair and reasonable reimbursement rate. Such charges do not establish what insurers customarily pay for the same or similar services in comparable circumstances.

   Permitting reimbursement based solely on the provider's billed charges would effectively place payment determination within the provider's unilateral control. This outcome would be inconsistent with:

   - The statutory objective of effective medical cost control, and
   - The requirement that reimbursement does not exceed the amount paid for similar treatment of an injured individual of an equivalent standard of living, as contemplated by Labor Code Section 413.011.

   Accordingly, usual and customary charges cannot be favorably considered absent additional objective data or documentation substantiating that the requested amount is fair and reasonable.

   The requester did not submit documentation to demonstrate how the requested reimbursement:

   - Ensures the quality of medical care, and
   - Achieves effective medical cost control as expressly required by Texas Labor Code Section 413.011.

The statute requires that reimbursement methodologies balance adequate provider compensation with system-wide cost containment. No evidence was provided to establish that the requested $2,800 per day satisfies this statutory framework.

The requester did not provide:

- Nationally recognized published studies,
- Independent fee analyses,
- Benchmarking data, or
- Documentation of values assigned to services involving similar work and resource commitments to substantiate the requested reimbursement amount.

Without objective comparative data, the Division cannot determine that the requested rate aligns with fair market values for services requiring comparable time, skill, intensity, and resources.

The requester did not establish that payment of the requested amount satisfies the requirements set forth in 28 TAC Section 134.1, which governs reimbursement when no fee guideline applies. The documentation submitted does not demonstrate that the requested rate is reasonable within the context of the Texas workers' compensation system.

4. At the MFDR level, the requester bears the burden of proof to establish entitlement to reimbursement by a preponderance of the evidence.

   DWC finds that the requester failed to submit sufficient documentation to support that the requested $2,800 per day constitutes a fair and reasonable reimbursement under applicable statutes and rules.

   Because the evidentiary burden has not been met, payment cannot be recommended.

Conclusion

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

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

________________ ________________ February 27, 2026

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 Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

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