TDI 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

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-23-1586-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

March 7, 2023

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 2, 2022	97799 Traumatic Brian Injury Services	$2,800.00	$0.00
May 4, 2022	97799	$2,800.00	$0.00
May 6, 2022	97799	$2,800.00	$0.00
May 11, 2022	97799	$2,800.00	$0.00
May 12, 2022	97799	$2,800.00	$0.00
May 13, 2022	97799	$2,800.00	$0.00
May 19, 2022	97799	$2,800.00	$0.00
May 20, 2022	97799	$2,800.00	$0.00
May 24, 2022	97799	$2,800.00	$0.00
May 25, 2022	97799	$2,800.00	$0.00

May 26, 2022	97799	$2,800.00	$0.00
May 27, 2022	97799	$2,800.00	$0.00
August 2, 2022	97799	$2,800.00	$0.00
August 3, 2022	97799	$2,800.00	$0.00
August 4, 2022	97799	$2,800.00	$0.00
August 5, 2022	97799	$2,800.00	$0.00
August 15, 2022	97799	$2,800.00	$0.00
August 16, 2022	97799	$2,800.00	$0.00
September 26, 2022	97799	$2,800.00	$0.00
September 27, 2022	97799	$2,800.00	$0.00
September 28. 2022	97799	$2,800.00	$0.00
September 30, 2022	97799	$2,800.00	$0.00
October 13, 2022	97799	$2,800.00	$0.00
October 14, 2022	97799	$2,800.00	$0.00
October 17, 2022	97799	$2,800.00	$0.00
October 18, 2022	97799	$2,800.00	$0.00
October 19, 2022	97799	$2,800.00	$0.00
October 20, 2022	97799	$2,800.00	$0.00
October 21, 2022	97799	$2,800.00	$0.00
	Total	$81,200.00	$0.00

Requester's Position

"…we were paid at the Chronic Pain Management's Fee Schedule. This was not negotiated with us but said to be fair and reasonable per your company. We pre-authorized a 'Brain Injury Program' and per the TDI Guidelines a fee schedule has not been determined for this type of treatment, nor

has a modifier been assigned. This is a complex program and continues to need constant supervision from multiple providers. At this time, we are asking that these claims be sent back for Reprocessing for an agreed fair and reasonable rate based on §134.202".

Supplemental Position Summary: "I believe that the payment amount being sought for the traumatic brain injury program provided to J.S. is fair and reasonable, considering the severity and complexity of the injury, the customized treatment plan, the expertise of the providers, comparable rates in the region, the positive outcomes achieved, the successful previous rebuttal, and the established payment history with the insurance company. I appreciate your attention to this matter and look forward to a favorable resolution".

Amount In Dispute: $81,200.00

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 $13,440.00. Required modifiers never billed and no payment agreement in place".

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. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. Labor Code Section 413.011 sets out the policies and guidelines for medical fee dispute resolution.
3. 28 TAC Section 133.305 sets out the general medical fee dispute resolution process.
4. 28 TAC Section 134.1 sets out the guidelines for reimbursement.

Adjustment Reasons

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

1. 1 – Brain injury program, modifier CP needed. Previous gross recommended payment amounts online: $0.

2. 1, 2 – Time indicated on the report; previous gross recommended payment amount on line: $0; Previous recommended payment amount no line: $0.
3. 193 – Original payment decision is being maintained. This claim was processed properly the first time.
4. 3 – ICD does not match D code.
5. 1 – Modifier -CP required previous gross recommended payment amount on line: $0
6. 1, 3, (16) – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
7. 2, 5, 7 – A technical bill review has been performed.
8. 3, 7 – No reimbursement value for this procedure based on usual, customary & reasonable for this geographic region. Please provide supportive documentation.
9. 6, 7, 8 – Previous recommended history.
10. 2, 3 – We are in receipt of your appeal that has been submitted and replied to more than once. This denial is our final response, unless additional information that would alter our decision is submitted in the future.
11. 148, 4, 3, 2 – This procedure on this date was previously reviewed.
12. 1 – Previous gross recommended payment amounts online: $0, previous recommended payment amount online: $0.
13. 1, 2, 3 – The appropriate modifier was not utilized.
14. 3, 4 (193) – Original payment decision is being maintained. This claim was processed properly the first time.
15. 4, 5 – The procedure code is inconsistent with modifier used or a required modifier is missing.
16. 4, 5, 6 – This appeal is denied as we the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
17. 2 – Request for reconsideration reviewed. No further payment is recommended. The appropriate modifier was not utilized. Modifier CP is required.
18. 7, 8, 9, (W3) – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
19. 3, 4, 5, (18) – Duplicate claim/service.

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. This dispute concerns the billing for services provided under unlisted CPT code 97799, specifically for a traumatic brain injury (TBI) treatment program rendered on May 2, 2022 to October 21, 2022. The provider billed and is requesting reimbursement for this service at a rate of $2,800 per day, which the insurance carrier denied after auditing the claim using the

specified reduction codes indicated above.

2. This dispute pertains to the non-payment of a traumatic brain injury program rendered on May 2, 2022 to October 21, 2022, and billed under CPT code 97799. 28 TAC Section 134.1 sets out the guidelines for reimbursement for medical services.

   Specifically, 28 TAC Section 134.1(e) states that healthcare services not provided through a workers' compensation healthcare network must be reimbursed based on:

   - 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 under the Division's fee guidelines and neither party submitted documentation for a negotiated contract. Accordingly, the service in dispute falls to a fair and reasonable reimbursement amount as set out in 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. The requester claims a contracted fee schedule with Coventry supports payment of $2,800 per day and provided redacted patient checks but did not provide any supporting documentation or the alleged contract. Because of this lack of evidence, the contract referred to by the requester is not considered in determining whether the requester is or is not entitled to the $2,800.00 sought.

   2. Redacted Explanation of Benefits (EOBs) from various insurance carriers, which shows payments ranging between $2,240 and $2,360, and one EOB reflecting a payment of $2,800.00.

   3. One (1) Medical Fee Dispute Resolution (MFDR) decision.

   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

Signature	Medical Fee Dispute Resolution Officer	February 27, 2026 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.