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

General Information

Requester Name
North Texas Rehabilitation Center

Respondent Name
Ohio Security Insurance Co

MFDR Tracking Number
M4-25-2409-01

Insurance Carrier's Austin Representative
BOX 60 Downs Stanford PC

DWC Date Received
May 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2024 – December 16, 2024	97799-CA	$51,100.00	$0.00
	Total	$51,100.00	$0.00

Requester's Position

"The denial was for 'Inconsistent Modifier'. We billed a 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… This is a complex program and continues to need constant supervision from multiple providers. 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: $51,100.00

Respondent's Position

"Bills for DOS 7/24/2024 -12/16/2024 has been reviewed and denial stand as provider did not bill the appropriate modifier per TX Rule 134.204 (h)…"

Response Submitted By: Liberty Mutual

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:

- 10 – THE BILLED SERVICE REQUIRES THE USE OF A MODIFIER CODE.
- X598 - CLAIM HAS BEEN RE-EVALUATED BASED ON ADDITIONAL DOCUMENTATION SUBMITTED, NO ADDITIONAL PAYMENT DUE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

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 $51,100.00?
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 from July 24, 2024, through December 16, 2024. The provider billed and is requesting reimbursement for these services at a total rate of $51,100.00 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 July 24, 2024, through December 16, 2024, 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 covered under the Division's fee guidelines and neither party submitted documentation for a negotiated contract. Hence, 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.

   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 $51,100.00 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 $51,100.00 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 $51,100.00 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 19, 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.