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

**Requestor Name**
Pride

**Respondent Name**
Emcasco Insurance Co

**MFDR Tracking Number**
M4-25-0799-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 9, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 21, 2024 | 97799-CP-CA-GP-GO | $1000.00 | $0.00 |

## Requestor's Position

"The denial for pre-authorization is in error; please submit the claim back for processing of payment as we have met the requirements of the pre-authorization."

**Amount in Dispute:** $1,000.00

## Respondent's Position

The Austin carrier representative for Emcasco is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on December 17, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §134.600 sets out the requirements of prior authorization.

2. 28 TAC §134.204 sets out the medical fee guideline for workers' compensation specific services.

3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 39 – Services denied at the time authorization/pre-certification was requested.

Issues

1. Is insurance carrier's denial based on lack of prior authorization supported?

Findings

1. The requestor is seeking payment of charges billed for **97799**, -**CP -CA** -GP -GO for date of service May 21, 2024. Review of 28 TAC 134.204 (h)(5)(A) states in pertinent parts, "(5) The following shall be applied for billing and reimbursement of **Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs**. (A) Program shall be billed and reimbursed using CPT Code **97799 with modifier "CP**" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "**CA**" as a second modifier.

   The document from GENEX dated March 13, 2024 titled, "Review #6359701" indicates, "…Recommend prospective request for 1 initial **functional restoration program** (80 hours) between 3/11/2024 and 7/10/2024 be certified.

   DWC Rule 28 TAC §134.600 (p)(1) states in pertinent parts, "Non-emergency health care requiring preauthorization includes chronic pain management/interdisciplinary pain rehabilitation."

   Review of the submitted documentation was insufficient to support prior authorization was obtained for chronic pain management/interdisciplinary pain rehabilitation. The insurance carrier's denial is maintained. No payment 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.

DWC finds the requestor has not established that additional reimbursement is due.

## Order

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

**Authorized Signature**

| | | |
|---|---|---|
| | Medical Fee Dispute Resolution Officer | March 6, 2025 |
| Signature | | 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 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 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 tres o correo electronico CompConnection@tdi.texas.gov.