



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

PRIDE

Respondent Name

Arch Indemnity Insurance Company

MFDR Tracking Number

M4-25-0822-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 23, 2024	97799-CP-CA-GP-GO x 6	\$635.00	\$635.00
July 26, 2024	97799-CP-CA-GP-GO x 6	\$635.00	\$635.00
July 30, 2024	97799-CP-CA-GP-GO x 6	\$635.00	\$635.00
August 6, 2024	97799-CP-CA-GP-GO x 6	\$635.00	\$635.00
August 8, 2024	97799-CP-CA-GP-GO x 6	\$635.00	\$635.00
September 17, 2024	97799-CP-CA-GP-GO x 7	\$875.00	\$175.00
September 20, 2024	97799-CP-CA-GP-GO x 7	\$875.00	\$175.00
October 18, 2024	97750-FC-GO x 6	\$500.00	\$0.00
Total		\$5,425.00	\$3,525.00

Requestor's Position

"The claim was reduced to \$0 per hour with the rational code of fair and reasonable. The current procedural terminology code 97799-CP-CA is an unlisted physical medicine/rehabilitation service and/or procedure. The modifier CP is for chronic pain management and the CA modifier is for CARF accredited programs. The commission agrees with the commenter's support of the reimbursement rate for interdisciplinary pain management programs in the amount of \$125.00 per hour is the maximum allowed reimbursement for this procedure code."

Amount in Dispute: \$5,425.00

Respondent's Position

The Austin carrier representative for Arch Indemnity Insurance Company is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on December 17, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

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 §134.230](#), sets out the reimbursement guidelines for return-to-work rehabilitation programs.
3. [28 TAC §134.204](#) sets medical fee guidelines for Workers' Compensation Specific Services

Denial Reasons

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

- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 00100 - Any network reduction is in accordance with the network referenced above.
- 00663 - Reimbursement has been calculated based on the state guidelines.
- 309 - The charge for this procedure exceeds the fee schedule allowance.
- 877 - Reimbursement is based on the contracted amount.
- 90109 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 93 - No claim level adjustment.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- P24 - Payment adjusted based on Preferred Provider Organization (PPO).

Issues

1. Is the network reduction in reimbursement applied to the disputed service by the insurance carrier, supported?
2. Is CPT code 97750-FC dated October 18, 2024, eligible for review?
3. Are the disputed services preauthorized?

4. Is the requestor entitled to reimbursement for the chronic pain management services?

Findings

1. The requestor seeks reimbursement for CARF accredited chronic pain management services billed under CPT code 97799-CP-CA. A review of the explanation of benefits (EOB) submitted finds that a network reduction was deducted from the reimbursement of the disputed service. Based on a review of the submitted documentation and information known to DWC, this injured employee's Texas Worker's Compensation claim is a non-network claim. Therefore, DWC finds that the network reduction applied to the reimbursement of the service in dispute is not supported.

2. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines. The requestor seeks reimbursement for CPT code 97750-FC x 6 units with a date of service, October 18, 2024, identified on the table of disputed services.

28 TAC §133.307 states, "(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include: ... (K) each explanation of benefits or e-remittance (collectively 'EOB') related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;"

A review of the submitted documentation finds no copies of EOBs for date of service October 18, 2024. The EOBs provided are for date of service April 23, 2024, which was not identified on the table of disputed services. DWC finds that CPT code 97750-FC for date of service October 18, 2024 is not eligible for review, pursuant to 28 TAC 13.307 (2)(K).

3. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

28 TAC §134.230(1)(A) states "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 §134.230(5) states, "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 unit's column on the bill. CARF accredited programs shall add "CA" as a second modifier. (B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The insurance carrier did not respond to the medical fee dispute resolution request. No

documentation was submitted by the insurance carrier in support of the denial reasons.

The requestor submitted a copy of a preauthorization letter issued by Medinsights dated May 28, 2024, preauthorizing 80 hours of CPT code 97799, a "functional restoration program." The DWC finds that the disputed service was preauthorized, and therefore reimbursement is recommended.

4. Review of the submitted documentation finds that the requestor billed CPT Code 97799-CP and appended modifier –CA to identify that the chronic pain management program is CARF accredited, as a result, reimbursement is calculated per 28 TAC §134.230(1)(A) and 28 TAC §134.230(5)(A)-(B).

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR \$125/hour	Amount Due
07/23/24	97799-CP-CA-GP-GO	6	\$635.00	\$115.00	\$750.00	\$635.00
07/26/24	97799-CP-CA-GP-GO	6	\$635.00	\$115.00	\$750.00	\$635.00
07/30/24	97799-CP-CA-GP-GO	6	\$635.00	\$115.00	\$750.00	\$635.00
08/06/24	97799-CP-CA-GP-GO	6	\$635.00	\$115.00	\$750.00	\$635.00
08/08/24	97799-CP-CA-GP-GO	6	\$635.00	\$115.00	\$750.00	\$635.00
09/17/24	97799-CP-CA-GP-GO	7	\$875.00	\$700.00	\$875.00	\$175.00
09/20/24	97799-CP-CA-GP-GO	7	\$875.00	\$700.00	\$875.00	\$175.00
TOTALS		44	\$4,925.00	\$1,975.00	\$5,500.00	\$3,525.00

The total allowable reimbursement for the services in question is \$5,500.00. Arch Indemnity Insurance Company reimbursed \$1,975.00. An additional reimbursement of \$3,525.00 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 requestor has established that additional reimbursement of \$3,525.00 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 \$3,525.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 3, 2025

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, 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 electrónico CompConnection@tdi.texas.gov.