



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Marcus P. Hayes, D.C.

Respondent Name

American Casualty Co of Reading PA

MFDR Tracking Number

M4-25-1702-01

Insurance Carrier's Austin Representative

BOX 57 Continental Casualty Co

DWC Date Received

March 27, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2024	97799-CP	\$400.00	\$400.00
November 19, 2024	97799-CP	\$400.00	\$400.00
November 20, 2024	97799-CP	\$400.00	\$400.00
November 21, 2024	97799-CP	\$400.00	\$400.00
November 22, 2024,	97799-CP	\$400.00	\$400.00
November 25, 2024	97799-CP	\$400.00	\$400.00
November 26, 2024	97799-CP	\$400.00	\$400.00
December 2, 2024	97799-CP	\$400.00	\$400.00
December 3, 2024	97799-CP	\$400.00	\$400.00
December 4, 2024	97799-CP	\$400.00	\$400.00
Total		\$4,000.00	\$4,000.00

Requester's Position

"Sedgwick did not pay CPT 97799 correctly and the insurance carrier took a network reduction of \$4000 which should not have been applied as this is a NON-NETWORK claim... We ask that you review carefully and advise payment to be issued".

Amount In Dispute: \$4,000.00

Respondent's Position

"The Carrier contends a Division of Workers' Compensation Medical Fee Dispute Resolution does not have jurisdiction over this claim because this is a network claim with First Health Coventry Healthcare Network. Please see Exhibit "B". Resolution of any fee dispute should be directed to First Health Coventry Healthcare Network, not the Division of Workers' Compensation Medical Fee Dispute Resolution. The Carrier contends a proper network reduction was taken, and Respondent should not be entitled to further reimbursement".

Response Submitted By: Silvera Deary Ray

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. 28 TAC Section [134.230](#) sets out the Return-to-Work Rehabilitation Programs.
3. Texas Insurance Code (TIC) [Chapter 1305](#) governs workers' compensation health care networks.
4. [28 TAC Sections 10.120 through 10.122](#) address the submission of a complaint by a health care provider to the Health Care Network.

Adjustment Reasons

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

- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.

- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 1126 – This reconsideration reflects corrected charge amounts.
- 2005 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 2008 – Additional payment made on appeal/reconsideration.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5191 – This amount has been determined to have been paid in excess of the correct allowance; therefore, an overpayment request is being issued.
- 5279 – Contract disputes need to be sent to the network for review. Please forward any disputes/inquiries regarding the PPO discount to Coventry. Provider’s phone services for Coventry is 800-937-6624.
- 877 – Reimbursement based on the contracted amount.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on Workers’ Compensation jurisdictional regulations or payment policies.
- W3 – Bill is a reconsideration or appeal.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- CO – The amount adjusted due to a contractual obligation between the provider and the payer it is not the patient’s responsibility under any circumstances.
- Network reduction: Coventry P&T priced using a Coventry contract.

Issues

1. What is DWC considering in this medical fee dispute?
2. Does the division have jurisdiction to review this medical fee dispute?
3. Is the requester entitled to additional reimbursement?

Findings

1. The Division of Workers’ Compensation (DWC) is considering whether the health care provider is entitled to additional reimbursement for chronic pain management services rendered to an injured employee. The dispute services are outlined below:
 - Service: Chronic Pain Management Program
 - CPT Code: 97799 with modifier CP

- Dates of Service: November 18, 2024 – December 4, 2024
- Accreditation Status: Non-CARF accredited
- Amount Billed: \$800 per date of service (8 hours)
- Amount Paid by Carrier: \$400 per date of service
- Amount in Dispute: \$400 per date of service
- Total Dispute Amount: \$4,000

The provider requested reimbursement under 28 TAC Section 134.230, which governs reimbursement for Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

2. The insurance carrier asserts that the claim was a network claim through First Health Coventry Healthcare Network and therefore, DWC MFDR lacks jurisdiction under 28 TAC Sections 133.305 and 133.307, which limit DWC review to non-network claims and certain out-of-network services. In this case, the DWC determined the carrier failed to support network enrollment because:

- No documentation was provided showing the injured employee was enrolled in a certified Health Care Network (HCN).
- The carrier only produced a screen print stating “HCN eligible – 10/09/2023”.
- The document did not identify the network name or confirm actual enrollment.
- No evidence showed the provider was contractually required to follow network procedures.

Additionally, DWC records contained no notice from the carrier reporting that the employee was enrolled in a certified HCN.

- Texas Labor Code §413.031(a)(1) – providers may request review when payment is denied or reduced.
- Texas Labor Code §413.031(c) – DWC adjudicates payment disputes for medically necessary services.

Therefore, the DWC concluded it does have jurisdiction to resolve the dispute.

3. The requester seeks additional reimbursement for non-CARF accredited chronic pain management services billed under CPT Code 97799-CP at \$800.00 per date of service, rendered from November 18, 2024, through December 4, 2024. The insurance carrier reimbursed \$400.00 per date of service, and the requester seeks the remaining balance. Because the carrier’s reduction reason is unsupported, reimbursement will be determined in accordance with 28 TAC Section 134.230.

28 TAC Section 134.230(5) states that Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour, with the number of hours indicated in the units column on the bill. CARF-accredited programs must append the "CA" modifier as a second modifier. The rule further establishes reimbursement at \$125 per hour, with units of less than one hour prorated in 15-minute increments.

Additionally, 28 TAC Section 134.230(1)(B) reimbursement for a non-CARF accredited program shall be 80 percent of the Maximum Allowable Reimbursement (MAR).

The requester billed CPT Code 97799-CP; therefore, the program is considered non-CARF accredited, and reimbursement is limited to 80 percent of the MAR.

A review of the submitted bills indicates the requester billed eight units per date of service. Applying the applicable reimbursement methodology, the MAR is calculated as \$100.00 per hour, resulting in \$800.00 per date of service.

The DWC finds that the total allowable reimbursement for the disputed services is \$8,000.00. The insurance carrier previously issued payments totaling \$4,000.00. Therefore, the requester is entitled to additional reimbursement in the amount of \$4,000.00 for the services in dispute.

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 established that additional reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that American Casualty Company of Reading must remit to Marcus, P. Hayes, D.C., \$4,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 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 electrónico CompConnection@tdi.texas.gov.