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
Mid-Century Insurance Company

MFDR Tracking Number
M4-25-1768-01

Carrier's Austin Representative
Box Number 14

DWC Date Received
April 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 1, 2024	97799 CP	$625.00	$0.00
April 2, 2024	97799 CP	$625.00	$500.00
April 3, 2024	97799 CP	$625.00	$500.00
April 4, 2024	97799 CP	$625.00	$500.00
April 5, 2024	97799 CP	$625.00	$500.00
April 8, 2024	97799 CP	$625.00	$500.00
April 9, 2024	97799 CP	$625.00	$500.00
April 10, 2024	97799 CP	$625.00	$500.00
April 11, 2024	97799 CP	$625.00	$500.00
April 12, 2024	97799 CP	$625.00	$500.00
April 16, 2024	97799 CP	$625.00	$500.00
April 17, 2024	97799 CP	$625.00	$500.00
April 18, 2024	97799 CP	$625.00	$500.00

April 19, 2024	97799 CP	$625.00	$500.00
April 29, 2024	97799 CP	$625.00	$500.00
April 30, 2024	97799 CP	$625.00	$500.00
May 13, 2024	97799 CP	$625.00	$500.00
May 14, 2024	97799 CP	$625.00	$500.00
May 15, 2024	97799 CP	$625.00	$500.00
May 16, 2024	97799 CP	$625.00	$500.00
May 20, 2024	97799 CP	$625.00	$500.00
May 21, 2024	97799 CP	$625.00	$500.00
May 22, 2024	97799 CP	$625.00	$500.00
May 23, 2024	97799 CP	$625.00	$500.00
May 24, 2024	97799 CP	$625.00	$500.00
May 30, 2024	97799 CP	$625.00	$500.00
June 7, 2024	97799 CP	$625.00	$500.00
June 10, 2024	97799 CP	$625.00	$500.00
June 11, 2024	97799 CP	$625.00	$500.00
June 12, 2024	97799 CP	$625.00	$500.00
June 14, 2024	97799 CP	$625.00	$500.00
June 17, 2024	97799 CP	$625.00	$500.00
June 19, 2024	97799 CP	$625.00	$500.00
June 20, 2024	97799 CP	$625.00	$500.00
June 21, 2024	97799 CP	$625.00	$500.00
June 25, 2024	97799 CP	$625.00	$500.00
	Total	$22,500.00	$17,500.00

Requester's Position

"Per your explanation of benefits, the above-mentioned claim has been denied due to: Workers' compensation jurisdictional fee schedule adjustment. Since this referral is involving the Designated Doctor exam and was approved/medically necessary …."

Amount in Dispute: $22,500.00

Respondent's Position

The Austin carrier representative for Mid-Century Insurance Company is Farmers Insurance Group. Farmers Insurance Group was notified of this medical fee dispute on April 9, 2025. 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 (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) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the Return-to-Work Rehabilitation Programs.
3. 28 TAC §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 11 – The diagnosis is inconsistent with the procedure.
- 229 – Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate the charge upon receipt of clarifying information.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: History bill processed correctly. No additional allowance is recommended.
- 243, XES – Services not authorized by network/primary care providers.
- 95 – Plan procedures not followed.
- U04, U03 – The billed services exceed the UR amount authorized.
- Note: PLN 1 filed disputing medical treatment is related after 12/26/23
- G15 – Pricing is calculated based on the medical professional fee schedule value.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- Note: Additional allowance recommended.
- 11 – Reimbursement is based on insurer re-coding. (The insurer must specify the health care provider.)
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.
- N45 – Payment based on authorized amount.
- N54 – Claim information is inconsistent with pre-certified/authorized services.
- 397 – Allowance based on utilization review pre-authorization.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount and must not duplicate provider adjustment amount payment and contractual.
- W3 – Additional payment made on appeal/reconsideration.
- U01 – There was no UR procedure/treatment request received.
- Note: No additional allowance is made as we are upholding the adjusters denial.

Issues

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason 229?
2. Is the claim part of a certified healthcare network?
3. Is the date of service April 1, 2024, eligible for review?
4. Is the insurance carrier's denial reason supported?
5. Is the requester entitled to reimbursement?
6. What rule applies to the reimbursement of disputed services?

Findings

1. The requester is seeking Medical Fee Dispute Resolution (MFDR) in the amount of $22,500 for chronic pain management services rendered between April 1, 2024, and June 25, 2024.

   The insurance carrier denied the disputed prescriptions with denial code "229 – Procedure does not appear related to the injury and/or diagnosis" and "11 – The diagnosis is inconsistent with the procedure." A note on the explanation of benefits (EOB) dated May 7, 2024, states "PLN 1 filed disputing medical treatment is related after 12/26/23"

   28 TAC §133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requester in the form and manner prescribed by the division… (H) If the medical fee dispute involves compensability, extent of injury, or liability,

the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

Review of the documentation submitted by the requester finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requester or that the requester had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC; therefore, the DWC finds that the extent of injury denial was not timely presented to the requester. Because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. For that reason, this matter is addressed pursuant to the applicable rules and guidelines.

2. The requester is seeking reimbursement for professional medical services totaling $22,500 0, rendered on several dates between April 1, 2024, and June 25, 2024. The carrier denied these services citing reason code 243 – Services not authorized by network or primary care providers and 45 with the explanation "charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement".

   Texas Insurance Code Section 1305.006 states, in relevant part, that health care provided by an out-of-network provider must be pursuant to a referral from the injured employee's treating doctor and approved by the network in accordance with Section 1305.103.

   A review of the submitted documentation and information available to the division reveals insufficient evidence that the injured worker is enrolled in a certified healthcare network. Therefore, the carrier's denial is not supported. Consequently, the disputed services are reviewed in accordance with the applicable rules and guidelines.

3. The service in question was initially performed on April 1, 2024. The medical fee dispute was received by the Division on April 2, 2025. This date is more than a year following the in-question date of service.

   28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requester must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

   28 TAC §133.307 (c) (1) (A) states, "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

A review of the submitted documentation finds that the disputed service does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requester has failed to timely file this dispute with the Division; consequently, the requester has waived the right to medical fee dispute resolution for date of service April 1, 2024.

4. The requester is seeking Medical Fee Dispute Resolution (MFDR) in the amount of $22,500 for chronic pain management services rendered between April 2, 2024, and June 25, 2024. The insurance carrier denied the preauthorized chronic pain management program, referencing denial reason codes N45, N54, 397, and U01, as previously described.

   28 TAC §134.600 (p) states, "non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation…"

   The requester submitted a copy of two preauthorization letters issued by Genex, the first dated February 29, 2024, preauthorizing Chronic Pain Management Program x 80 hours with a start date of February 27, 2024, and an end date of June 26, 2024.The second dated April 3, 2024, preauthorizing Chronic Pain Management Program x 80 hours with a start date of April 1, 2024, and an end date of July 30, 2024.

   28 TAC §134.600 (c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The DWC finds that the service in dispute was rendered within the preauthorized timeframes. As a result, the insurance carrier's denial reason is not supported, and the requester is therefore entitled to reimbursement for the services in dispute.

   Per 28 TAC §134.600(p)(10), non-emergency health care services requiring preauthorization include chronic pain management and interdisciplinary pain rehabilitation programs. The documentation confirms the requester obtained proper preauthorization for the disputed services.

   Specifically:

   - **February 29, 2024:** The requester received preauthorization for 80 hours of chronic pain management, valid from 2/27/24 through 6/26/24.
   - **April 3, 2024:** A second preauthorization for chronic pain management was granted for another 80 hours, valid from 4/1/24 through 7/30/24.
   - **May 2, 2025:** The requester received preauthorization for 80 hours of functional restoration program, valid from 4/30/24 through 08/29/24.

- **June 5, 2024:** A second preauthorization for functional restoration program was granted for another 80 hours, valid from 5/31/24 through 9/30/24.

The services in dispute were rendered between April 2, 2024, and June 25, 2024—dates which fall within the approved preauthorization periods.

Therefore, the DWC determines that:

- The requester complied with the preauthorization requirements.
- A total of 160 hours of chronic pain management were preauthorized.
- A total of 160 hours of functional restoration program were preauthorized.
- The carrier's denial is not supported by the documentation.

Reimbursement is warranted per 28 TAC §134.600(c)(1)(B), which states that the carrier is liable for the medically necessary health care when preauthorization has been obtained.

5. The applicable fee guideline for chronic pain management services is outlined in 28 TAC §134.230. The requester billed CPT Code 97799 with modifiers "CP" and "CA," indicating a CARF-accredited chronic pain management program.

   Per 28 TAC §134.230:

   - Section (1)(B) specifies that non-CARF-accredited programs are reimbursed at 80% of the Maximum Allowable Reimbursement (MAR).
   - Section (5)(A)-(B) mandates that CPT Code 97799 with modifier "CP" (and "CA" for CARF-accredited programs) be reimbursed at $125 per hour, prorated in 15-minute increments.

   The provider initially used an incorrect modifier when billing for the CARF-accredited program, as indicated by the documentation. This error was later identified and corrected with the appropriate code and modifier (97799-CP) for non-CARF accredited services. Based on this correction, the DWC determines that the requester billed the disputed services in accordance with applicable rules. Therefore, the requester is entitled to reimbursement of 80% of the MAR rate for non-CARF accredited services, calculated according to the documented number of units billed.

DOS	CPT Code	No. Units	Amount in Dispute	IC Paid	80% MAR $100/hour	Amount Due
4/2/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/3/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/4/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/5/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00

4/8/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/9/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/10/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/11/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/12/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/16/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/17/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/18/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/19/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/29/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
4/30/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/13/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/14/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/15/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/16/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/20/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/21/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/22/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/23/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/24/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
5/30/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/7/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/10/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/11/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/12/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/14/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/17/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/19/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/20/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/21/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
6/25/24	97799 CP	5	$625.00	$0.00	$500.00	$500.00
		Total	$21,875.00	$0.00	$17,500.00	$17,500.00

The requester disputes $625 for 5 hours of chronic pain management on each of the disputed dates of service, for a total amount of $21,875.00. The MAR amount is calculated at $100/hour for 180 hours for a total amount of $17,500.00.

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $17,500.00 is due.

Conclusion

The Division of Workers' Compensation (DWC) concludes that the insurance carrier's denials are not supported by the evidence. This decision is based on a comprehensive review of all documentation submitted by both parties at the time of adjudication. While not all evidence is cited in this summary, it was fully considered in the determination process.

1. The denial reason provided is unsupported, as preauthorization was properly obtained and services were rendered within authorized timeframes.
2. The requester is entitled to reimbursement in the amount of $17,500.00 per 28 TAC §134.230, as the billed services comply with the fee guidelines.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requester $17,500.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 4, 2025
Signature	Medical Fee Dispute Resolution Officer	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 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 electronico CompConnection@tdi.texas.gov.