



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

North Texas Pain Recovery Center

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-25-2040-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

May 1, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 21, 2025	97799-CP-CA	\$1,400.00	\$0.00

Requestor's Position

"This claim was originally submitted by mail on 02/26/2025. We did receive an EOB of denial for an exact duplicate for the date of service 02/21/2025. This is not a duplicate of this date of service 02/21/2025."

Amount in Dispute: \$1,400.00

Respondent's Position

"On the DWC-60, Table of Disputed Services, Requestor has indicated the billed amount for the date of service 2/21/2025, is \$1,400.00, and they are seeking reimbursement in that amount. However, that is not the amount originally billed to Respondent. Please see the attached bill received by Respondent on 2/28/2025. It shows the charges for date of service 2/21/2025, were \$700.00. Additionally, please see the attached EOBs, which shows that the Provider was reimbursed a total of \$500.00, per the fee guidelines for 4 hours of chronic pain management per the DWC Rules. In conclusion, Requestor is not owed any additional reimbursement for the true amount billed to Respondent as Respondent has correctly reimbursement Requestor for the units originally billed."

Response Submitted by: Downs & Stanford, P.C.

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 §134.600](#) sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Denial Reasons

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

- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 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.
- 1001 - Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2005 - No additional reimbursement allowed after review of appeal/reconsideration.
- 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.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 97799-CP-CA rendered on February 21, 2025. The insurance carrier issued a payment in the amount of \$500.00 on March 26, 2025 and reduced the remaining balance.

Reimbursement for chronic pain management services was found at 28 TAC §134.230.

28 TAC §134.230 states,

(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.

(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.

Documentation submitted supports that North Texas Rehabilitation Center performed and billed 4 hours of CARF accredited chronic pain management services on February 21, 2025. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

2. 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 requestor billed 97799-CP-CA; therefore, the disputed program is CARF accredited, and reimbursement shall be 100% of the MAR.

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
2/21/25	97799-CP-CA	4	\$500.00	\$500.00	\$500.00	\$0.00

The division finds that the requestor was paid the maximum allowable reimbursement (MAR) for the CARF accredited chronic pain management. As a result, additional reimbursement is not 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 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 additional reimbursement for the disputed service.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 6, 2025 Date
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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.