



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

PRIDE PLLC

Respondent Name

American Zurich Insurance Co

MFDR Tracking Number

M4-25-2297-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

May 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2025	97799-CP-CA-GP-GO	\$405.75	\$405.75
January 24, 2025	97799-CP-CA-GP-GO	\$529.75	\$529.75
January 28, 2025	97799-CP-CA-GP-GO	\$468.75	\$468.75
January 29, 2025	97799-CP-CA-GP-GO	\$530.75	\$530.75
January 30, 2025	97799-CP-CA-GP-GO	\$780.75	\$780.75
February 5, 2025	97799-CP-CA-GP-GO	\$968.75	\$968.75
February 25, 2025	97799-CP-CA-GP-GO	\$593.75	\$593.75
February 27, 2025	97799-CP-CA-GP-GO	\$780.75	\$31.25
April 2, 2025	97799-CP-CA-GP-GO	\$468.75	\$468.75
Total		\$5,527.75	\$4,778.25

Requester's Position

"The above date of service was denied in error. The claim was reduced to \$0 per hour with the rational code of fair and reasonable."

Amount in Dispute: \$5,527.75

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

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:

- N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.
- N45 - Payment based on authorized amount.
- 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.
- XXU03 - The billed service was reviewed by UR and authorized.
- 00663 - Reimbursement has been calculated based on the state guidelines.
- 93 - No claim level adjustment
- W3 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18 - Exact duplicate claim/service.
- TX224 - Duplicate charge.
- 198 - Precertification/notification/authorization/pre-treatment exceeded.
- N54 - Claim information is inconsistent with pre-certified/authorized services.
- XXU05 - The billed service exceeds the UR amount authorized.
- XXG15 - Pricing is calculated based on the medical professional fee schedule value.

Issues

1. Did the respondent submit a supplemental response as indicated in their position statement?
2. Is the Insurance carrier's denial reason supported?
3. Is the requester entitled to reimbursement?

Findings

1. A review of the respondent's documentation shows that Gallagher Bassett responded to the Medical Fee Dispute Resolution (MFDR) request on June 9, 2025. In their response, Gallagher Bassett stated that the bills had been escalated for manual review to determine if additional amounts were owed. However, as of the date of this review, no supplemental response has been submitted. Therefore, the decision is based solely on the information contained in the original MFDR request.
2. The requester is seeking reimbursement for CPT Code 97799-CP-CA-GP, provided on multiple dates between January 22, 2025, and April 2, 2025. A review of the table of disputed services indicates that the requester acknowledged payments of \$31.25 were issued for each of the disputed service dates, totaling \$281.25. The insurance carrier reduced payment for the remaining charges, citing the following denial codes:
 - XXU03 - The billed service was reviewed by UR and authorized
 - N45 - Payment based on authorized amount.
 - 198 - Precertification/notification/authorization/pre-treatment exceeded.
 - N54 - Claim information is inconsistent with pre-certified/authorized services.
 - XXU05 - The billed service exceeds the UR amount authorized.

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

The requester submitted two preauthorization letters issued by MedInsight:

- December 31, 2024: Authorization for Functional Restoration Program, 80 hours of CPT 97799, effective December 31, 2024, through March 31, 2025.
- March 3, 2025: Authorization for Functional Restoration Program, 80 hours of CPT 97799, with a start date of March 3, 2025; the end date is illegible.

According to 28 TAC §134.600(c)(1)(B), the insurance carrier is liable for all reasonable and necessary medical costs related to health care listed in subsection (p) when: "(B) preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care."

The insurance carrier contends that the preauthorization was exceeded, the services provided were inconsistent with the pre-certified/authorized services, and the services exceeded the amount authorized by UR.

However, the Division of Workers' Compensation (DWC) finds that the insurance carrier submitted insufficient documentation to demonstrate that the treatment from January 22, 2025, through April 2, 2025, exceeded either the authorized UR amount or the preauthorized amount indicated in the MedInsight preauthorization letters. Furthermore, the insurance carrier issued a partial payment of \$31.35 for each of the disputed dates of service.

Therefore, the DWC concludes that the services were rendered within the authorized timeframes, the insurance carrier's denial reason is not supported, and the requester is entitled to additional reimbursement for the services in dispute.

3. The requester seeks additional reimbursement for CARF accredited chronic pain management services billed under CPT code 97799-CP-CA and provided on January 22, 2025, through April 2, 2025. Because the insurance carrier's denial is not supported, the DWC finds that the requester is entitled to additional reimbursement for the services in dispute.

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."

Review of the submitted documentation finds that the requester billed CPT Code 97799-CP and appended modifier –CA to identify that the chronic pain management program is CARF accredited, and therefore reimbursement is recommended at 100% of the MAR, pursuant to per 28 TAC §134.230.

The reimbursement amount per hour is \$125.00 and is prorated in 15-minute increments. A 15-minute increment results in a payment amount of \$31.25. The following table outlines the recommended reimbursement amounts for each of the disputed dates of service.

DOS	CPT Code	# Units	MAR \$125/hour	IC Paid	MAR minus the IC payment	Amount in Dispute	Amount Due
1/22/2025	97799-CP-CA	3.5	\$437.50	\$31.25	\$406.25	\$405.75	\$405.75
1/24/2025	97799-CP-CA	4.5	\$562.50	\$31.25	\$531.25	\$529.75	\$529.75
1/28/2025	97799-CP-CA	4	\$500.00	\$31.25	\$468.75	\$468.75	\$468.75
1/29/2025	97799-CP-CA	4.5	\$562.50	\$31.25	\$531.25	\$530.75	\$530.75
1/30/2025	97799-CP-CA	6.5	\$812.50	\$31.25	\$781.25	\$780.75	\$780.75
2/5/2025	97799-CP-CA	8	\$1,000.00	\$0.00	\$1,000.00	\$968.75	\$968.75
2/25/2025	97799-CP-CA	5	\$625.00	\$31.25	\$593.75	\$593.75	\$593.75
2/27/2025	97799-CP-CA	6.5	\$812.50	\$781.25	\$31.25	\$780.75	\$31.25
4/2/2025	97799-CP-CA	4	\$500.00	\$0.00	\$500.00	\$468.75	\$468.75
TOTAL		46.5	\$5,812.50	\$968.75	\$4,843.75	\$5,527.75	\$4,778.25

The requester submitted a table of disputed services involving CPT code 97799-CP-CA provided across nine dates of service from January 22, 2025, through April 2, 2025, totaling 46.5 units. A review of the provider's table of disputed services and the corresponding Explanation of Benefits (EOBs) identified several discrepancies. The provider claimed that only \$281.25 had been reimbursed for the disputed services; however, EOBs confirm the insurance carrier actually paid \$968.75.

The provider also reported a total amount in dispute of \$5,527.75, however there appears to be a discrepancy primarily from the February 27, 2025 date of service, where the provider reported only \$31.25 in payment, while the EOB reflects a payment of \$781.25—a \$750.00 discrepancy. Correcting this reduces the actual disputed amount to \$4,778.25.

In accordance with Texas Labor Code §413.011 and 28 TAC §134.204(d), reimbursement must be the lesser of:

1. The Maximum Allowable Reimbursement (MAR),
2. The provider's usual and customary charge, or
3. A fair and reasonable amount.

In this case, the provider's request does not exceed the MAR, and no documentation supports a lower usual or customary charge.

- Total MAR: \$5,812.50
- Total Paid: \$968.75
- Remaining Balance: \$4,843.75
- Correct Amount Due (after correcting dispute error): \$4,778.25

This is the recommended reimbursement amount under Division rules.

Conclusion

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 additional reimbursement of \$4,778.25 is due.

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 \$4,778.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 14, 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, 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.