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
Pride

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-26-0230-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 23, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 21, 2025	97799-CP-CA-GP-GO	$750.00	$0.00
April 23, 2025	97799-CP-CA-GP-GO	$750.00	$0.00
April 25, 2025	97799-CP-CA-GP-GO	$1,000.00	$0.00
May 5, 2025	97799-CP-CA-GP-GO	$1,000.00	$0.00
May 7, 2025	97799-CP-CA-GP-GO	$1,000.00	$0.00
July 16, 2025	97799-CP-CA-GP-GO	$0.00	$0.00
July 18, 2025	97799-CP-CA-GP-GO	$500.00	$0.00
July 21, 2025	97799-CP-CA-GP-GO	$750.00	$0.00
July 22, 2025	97750-FC	$931.92	Dismissed
	Total	$6,687.92	$0.00

Requester's Position

"The medical treatment received by the above referenced patient was provided under the rules-of the Texas Department of Insurance, Division of Workers' Compensation. Set forth below is the

applicable portion of Rule 134.204 of the Texas Administrative Code: (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 a modifier "CP" for each hour. The number of hours shall be indicated in the unit(s) column on the bill. CARF accredited Programs shall ass 'CA' as a second modifier.

(B) Reimbursement shall be $125per hour.

As been explained to you, PRIDE is a CARF accredited interdisciplinary program qualified for reimbursement of the full $125 per-hour for each hour the injured worker was treated in the program."

Amount in Dispute: $6,687.92

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 24, 2025. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no position statement has been received from the insurance carrier or its representative. However, the carrier has provided explanation of benefits and payment documentation. We will base this decision on the information available at the time of review.

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 Medical Fee Dispute Resolution requests.

2. 28 TAC §134.230 sets out the medical fee guidelines for Return-to-Work Rehabilitation Programs.

3. 28 TAC §134.225 sets out the Fee Guidelines for Functional Capacity Evaluations.

Denial Reasons

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

- 1 – Billing provider is not on the report.
- 2 – Your report does not contain a clear, concise explanation of the service rendered.
- 16 – Claim/ service lacks information or has submission/billing errors which is needed for adjudication.
- 4 – A technical Bill Review has been performed.
- 5 – N713 – Incomplete/Invalid report.
- 6 – Services were not identified in report.
- P12 – Workers' Compensation Jurisdictional fee schedule adjustment.
- M51 – Missing/Incomplete/invalid procedure code(s).
- 1 – Please resubmit with a more appropriate CPT/HCPCS code that better reflects services documented.
- 1 – Charge exceeds fee schedule allowance.

Issues

1. What rules apply to the disputed services represented by CPT code 97799-CP-CA?

2. What rules apply to the disputed service represented by CPT code 97750-FC?

3. Does the documentation support that the services were provided as billed for dates of service rendered from April 21, 2025, through July 21, 2025?

4. Have any of the services in dispute received reimbursement? If so, is the requester entitled to additional reimbursement?

5. Is the requester entitled to reimbursement for CPT code 97750-FC rendered on July 22, 2025?

Findings

1. The requester is seeking reimbursement for CPT code 97799-CP-CA-GP-GO rendered on eight separate dates of service.

   CPT code 97799 is designated for unlisted physical medicine and rehabilitation services. Since this code represents an unlisted procedure, healthcare providers must provide thorough documentation to justify the service rendered. It is used when there is no specific CPT code available for a unique rehabilitation treatment. Common medical conditions treated with CPT code 97799 include Chronic Pain Management. For the purposes of workers' compensation, CPT code 97799-CP is used for the billing of return-to-work programs involving chronic pain management.

   DWC finds that 28 TAC §134.230, which sets out the fee guideline for chronic pain management services, applies to the reimbursement of CPT code 97799-CP. 28 TAC §134.230(1) 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). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 TAC §134.230(5), which applies to the billing and reimbursement of CPT code 97799-CP, 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."

2. The requester is seeking reimbursement for CPT code 97750-FC rendered on July 22, 2025.

   CPT code 97750 is described as Physical Performance Test or Measurement (e.g., musculoskeletal, functional capacity) with written report, each (unit) 15 minutes. CPT 97750 is intended to focus on patient performance of a specific activity or group of activities. There must be written evidence documenting the problem requiring the test, the specific test performed, and a separate measurement report. This report may include torque curves and other graphic reports with interpretation.

   The functional capacity examination is identified as a division-specific service with billing code 97750-FC. DWC finds that 28 TAC §134.225 applies to the service in dispute and states in pertinent part, "The following applies to functional capacity evaluations (FCEs) … FCEs shall be billed using CPT code 97750 with modifier 'FC.' FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title."

   Per 28 TAC §134.203 (b)(1), parties are required to apply Medicare payment policies, including its coding, billing, correct coding initiatives (CCI) edits, modifiers, and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules to workers' compensation coding, billing, reporting, and reimbursement of professional medical services.

3. A review of the submitted medical bills finds that on the following disputed dates of service, the requester billed:

   - April 1, 2025, 97799-CP-CA-GP-GO x 6 units
   - April 23, 2025, 97799-CP-CA-GP-GO x 6 units

- April 25, 2025, 97799-CP-CA-GP-GO x 8 units
- May 5, 2025, 97799-CP-CA-GP-GO x 8 units
- May 7, 2025, 97799-CP-CA-GP-GO x 8 units
- July 16, 2025, 97799-CP-CA-GP-GO x 7 units (according to the DWC060form submitted, this date of service is in dispute in the amount of $0.00; therefore July 16, 2025, will not be considered in this review)
- July 18, 2025, 97799-CP-CA-GP-GO x 5 units
- July 21, 2025, 97799-CP-CA-GP-GO x 6 units

After a review of the submitted medical reports, DWC is unable to verify time spent and activities performed on each disputed date of service to support the units of CPT code 97799 billed. DWC finds that the medical documentation submitted does not support the service of CPT 97799-CP-CA-GP-GO as billed on the above disputed dates of service. As a result, DWC cannot recommend reimbursement.

4. A review of the submitted explanation of benefits (EOB) finds that the disputed date of service July 18, 2025, has received reimbursement in the amount of $125.00 out of $800.00 charged.

   As discussed in finding number three above, the medical documentation submitted does not support the service and units of 97799-CP-CA-GP-GO as billed on July 18, 2025. Therefore, DWC cannot recommend additional reimbursement for these dates of service.

5. The requester is seeking reimbursement in the amount of $931.92 for 11 units of CPT code 97750-FC rendered on July 22, 2025.

   Pursuant to 28 TAC §133.307, the dispute is eligible for review if the requester has submitted documentation relevant to the disputed dates of service. Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed date of service, July 22, 2025.

   DWC finds the following: 28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   The requester has not provided evidence of the claim denial or reduction. The requester did not submit evidence of a request to the insurance carrier for an EOB. DWC concludes that the requester has not met the requirements of 28 TAC §133.307(c)(2)(K) and therefore, is not eligible for MFDR of the services in question rendered on July 22, 2025.

   The disputed date of service, July 22, 2025, is hereby dismissed in accordance with 28 TAC

§133.307.

RIGHTS TO RE-FILE (date of service July 22, 2025)

This dismissal is not a final decision by the Division of Workers' Compensation. 28 TAC §133.307 (f)(3) states that a dismissal is not a final decision by the division and the medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section.

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.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement in the amount of $0.00 for the disputed services.

Authorized Signature:

January 8, 2026

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 electronico CompConnection@tdi.tas.gov.