



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Marcus Hayes MD

Respondent Name

National Liability & Fire Ins

MFDR Tracking Number

M4-26-0519-01

Insurance Carrier's Austin Representative

BOX 6 Stone Loughlin & Swanson LLP

DWC Date Received

October 24, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 22, 2025	97799	\$960.00	\$800.00
July 23, 2025	97799	\$960.00	\$800.00
July 24, 2025	97799	\$960.00	\$800.00
July 25, 2025	97799	\$960.00	\$800.00
July 28, 2025	97799	\$960.00	\$800.00
July 29, 2025	97799	\$960.00	\$800.00
July 30, 2025	97799	\$960.00	\$800.00
July 31, 2025	97799	\$960.00	\$800.00
August 1, 2025	97799	\$960.00	\$800.00
August 4, 2025	97799	\$960.00	\$800.00
Total		\$9600.00	\$8,000.00

Requester's Position

...the carrier has denied the claim based on the workers compensation fee schedule with the services exceeds the UR but this is false we bill accordingly to the review#8608038 and sent the Texas Administrative Rule 134.230.

Amount In Dispute: \$9,600.00

Respondent's Position

The Austin carrier representative for National Liability & Fire Insurance is Stone Loughlin & Swanson. The representative was notified of this medical fee dispute on October 27, 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 response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 [134.600](#) sets out the requirements for prior authorization.
3. 28 TAC Section [134.230](#) sets out the reimbursement guidelines for return to work rehabilitation programs.

Adjustment Reasons

1. 350 – Bill has been identified as a request for reconsideration or appeal.
2. 95 – Plan procedures not followed.
3. G15 – Pricing is calculated based on the medical professional fee schedule value.
4. P12 – Workers' compensation jurisdictional fee schedule adjustment.
5. U05 – The billed services exceeds the UR amount authorized.

6. W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is DWC considering in this medical fee dispute?
2. Was prior authorization required and received.
3. What rule is applicable to reimbursement?
4. Is the requester due reimbursement?

Findings

1. The requester is seeking reimbursement for chronic pain management from July 22, 2025 through August 4, 2025 in the amount of \$9600. The insurance carrier denied the services as UR being exceeded. The disputed services will be reviewed per applicable fee guidelines.
2. 28 TAC 134.600 (p)(10) states, Non-emergency health care requiring preauthorization includes: chronic pain management/interdisciplinary pain rehabilitation.

Review of the submitted documentation from genex dated July 17, 2025 found the following:

- Review #8608038
- Approval start & end date: 07/17/2025-09/17/2025
- Certified
- CPM, 80 hours, 10 sessions at 5 times weekly for 2 weeks...

The insurance carrier did not respond to this request for MFDR. Insufficient evidence was found to support that this authorization was exceeded. The disputed services will be reviewed per applicable fee guidelines.

3. The applicable DWC fee guidelines are found in the following sections. 28 TAC Section 134.230(1)(A)(B) 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 Section 134.230(5)(A)(B) 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 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.

The submitted medical bill indicates for each date of service a total of eight units was submitted. Per the rules shown above the MAR calculation is $\$125 \times 80\% = \100.00 multiplied by eight units equals a total MAR of \$800.00 for each date of service.

- 4. The total MAR for dates of service July 22, 2025 through August 4, 2025 for chronic pain management is \$8,000.00. This amount is recommended.

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 reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that [Respondent Name] must remit to [Requester Name] \$[Amount] plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

		January 30, 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 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.