



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requester Name**

Marcus Paul Hayes, D.C.

**Respondent Name**

National Liability & Fire Ins

**MFDR Tracking Number**

M4-26-0521-01

**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
June 30, 2025	97799	\$960.00	\$800.00
July 1, 2025	97799	\$960.00	\$800.00
July 2, 2025	97799	\$960.00	\$800.00
July 3, 2025	97799	\$960.00	\$800.00
July 7, 2025	97799	\$960.00	\$800.00
July 8, 2025	97799	\$960.00	\$800.00
July 10, 2025	97799	\$960.00	\$800.00
July 11, 2025	97799	\$960.00	\$800.00
July 14, 2025	97799	\$960.00	\$800.00
July 15, 2025	97799	\$960.00	\$800.00
<b>Total</b>		<b>\$9,600.00</b>	<b>\$8,000.00</b>

## Requester's Position

"I am writing to request an MFDR for the following date of service date range of 06/30/25-07/15/25 a reconsideration was submitted on 09/06/25 for a bill that was not paid the carrier has denied the claim based on the workers compensation fee schedule with the service exceeds the UR but this is false we bill accordingly to the IRO review # [redacted] 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 LLP. The representative was notified of this medical fee dispute on October 27, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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 requirements for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 TAC Section [134.230](#) sets out the reimbursement guidelines for return-to-work rehabilitation programs
4. 28 TAC Section [134.204](#) sets out medical fee guidelines for Workers' Compensation Specific Services.

### Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

1. P12 – Workers' compensation jurisdictional fee schedule adjustment.

2. G15 – Pricing calculated based on the medical professional fee schedule value.
3. P13 - Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
4. U02 -The billed service was reviewed by UR and denied.
5. 350 – Bill has been identified as a request for reconsideration or appeal.
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. Is the insurance carrier's denial based on prior authorization supported?
3. Is the requester entitled to reimbursement?

### Findings

1. The requester is seeking reimbursement in the amount of \$9,600.00 for chronic pain management service rendered on multiple dates from June 30, 2025 through July 15, 2025. The insurance carrier did not respond to the medical fee dispute request. The disputed services will be reviewed per applicable fee guidelines.
2. The requester seeks reimbursement for a chronic pain management program. The insurance carrier denied the disputed services citing that the billed services were reviewed by UR and denied.

A review of the submitted documentation provided by the requester finds that an Independent Review Organization (IRO) decision for preauthorization review dated June 25, 2025, states that the previous adverse determination/adverse determinations should be overturned. The decision states, "The description of service or services in dispute: Chronic pain management program, 10 sessions (80 hours), [redacted], per 05/21/2025 order."

28 TAC Section 134.600(p)(10) states, "chronic pain management/interdisciplinary pain rehabilitation" services require preauthorization.

28 TAC Section 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..."

DWC finds that the services in dispute were preauthorized. 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.

3. The fee guideline for chronic pain management services is found in 28 TAC Section 134.230.

28 TAC Section 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."

28 TAC Section 134.230(1)(B) states, "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."

The requester billed 97799-CP. The disputed program is not CARF accredited, and reimbursement shall be 80% of the MAR for a recommended amount of \$100.00/hour.

DOS	CPT Code	# Units	Amount in Dispute	IC Paid	MAR \$100/Hour	Amount Due
6/30/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/1/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/2/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/3/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/7/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/8/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/10/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/11/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/14/2025	97799-CP	8	\$960	\$0	\$800	\$800
7/15/2025	97799-CP	8	\$960	\$0	\$800	\$800
TOTALS		\$80.00	\$9,600.00	\$0.00	\$8,000.00	\$8,000.00

The total MAR for dates of service June 30, 2025 through July 15, 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 National Liability & Fire Insurance remit to Marcus Paul Hayes, D.C., \$8,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 19, 2026

\_\_\_\_\_  
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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).