TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Auto & Work Injury Clinic – Daniel Beltran, DC

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1313-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

January 12, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 4, 2025	97799-CP-GP	$2400.00	$800.00
	Total	$2400.00	$800.00

Requester's Position

"The requester did not submit a position statement with this request for MFDR. They did submit a copy of a document titled, "Reconsideration that states, "Our office originally billed 8 units for CPT 97799, which is the correct amount authorized for the patient. However, when the payer processed the claim, the system reflected 32 units, which resulted in denial."

Supplemental respond March 24, 2026

"The claims for (redacted) have not yet been paid, and we have not received a response from the payer at this time."

Amount In Dispute: $2400.00

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 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 134.204 sets out medical fee guideline for workers' compensation specific services.
3. 28 TAC 134.600 sets out the requirements of prospective and concurrent review of health care.

Adjustment Reasons

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

- 198 – Pre-authorization/authorization exceeded.
- N54 – Claim information is inconsistent with pre-certified/authorized services.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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 supported?
3. Was authorization obtained for disputed date of service?
4. What rule is applicable to reimbursement?
5. Has DWC determined whether reimbursement is due to the requester?

Findings

1. The requester is seeking reimbursement of $2400.00 for chronic pain management services rendered on August 4, 2025. The insurance carrier responded that the claim was to be reviewed but no response was received

2. 28 TAC 134.204(h)(5)(A) 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.

Review of the submitted medical bill indicates the number of units as 8. The explanation of benefits from the insurance carrier indicates units as 32. DWC finds the insurance carrier did not process the medical bill as submitted by the requester and as explained in the request for reconsideration.

3. 28 TAC 134.600(p)(10) states, Non-emergency health care requiring preauthorization includes: chronic pain management/interdisciplinary pain rehabilitation.

   Review of the submitted documents found a Texas Utilization Review Approval dated August 1, 2025. The approval indicates Chronic Pain Management 10 sessions/80 hours. DOS July 31, 2025 through October 30, 2025 (97799). The disputed date of service is August 4, 2025. This date is within date range of authorized visits. The insurance carrier did not supplement their position to support the authorization was exceeded. Therefore, the insurance carrier's denial is not supported.

4. As seen above, (finding #2) the fee guideline for chronic pain management (code 97799) is found in 28 TAC 134.204(h)(5)(B) and states, 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 the units as 8. The submitted "Daily Notes" indicate a time in of 8:00 am and time out as 4:00 pm. The number of units is supported. 28 TAC 134.204 (h)(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.

   Based on the specifics of the rule shown above, the hourly reimbursement rate is 80% of $125 or $125 x 80% = $100.00. Eight units x $100 = $800.00.

5. DWC has determined the requester is entitled to the fee guideline for eight units of chronic pain management as a non-CARF accredited provider or $800.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 Zurich American Insurance Co

must remit to Auto & Work Injury Clinic – Daniel Beltran, DC $800 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		May 4, 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 electronico CompConnection@tdi.texas.gov.