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

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1410-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

January 20, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 22, 2025	97799-CP-GP	$2,400.00	$775.00
	Total	$2,400.00	$775.00

Requester's Position

"I am following up regarding the denial of this claim. The explanation of benefits states that the billed amount exceeded the authorized units. After reviewing the authorization, the claim file, and the EOBs, I identified two issues that require correction. 1. Authorized and Billed Units 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. … 2. Compensable Diagnosis According to the utilization review approval, the primary compensable diagnosis for CPT 97799 is [redacted]. This is the diagnosis listed under the "Auth Code DX" in the authorization. The additional diagnoses included in the clinical documentation-[redacted] and [redacted]-were part of the reviewed medical history, but the authorized diagnosis specifically tied to CPT 97799 is [redacted]."

Amount In Dispute: $2,400.00

Respondent's Position

The Austin carrier representative for Zurich American Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on January 22, 2026.

Per 28 Texas Administrative Code Section 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 the preauthorization, concurrent utilization review, and voluntary certification of health care
3. 28 TAC Section 134.230 sets out medical fee guidelines for Return-to-Work Rehabilitation programs.

Adjustment Reasons

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

1. 198 – Pre-authorization/authorization exceeded.
2. 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
3. N54 – Claim information with pre-certified/authorized services.
4. 00663 – Reimbursement has been calculated based on the state guidelines.
5. XXG02 – Codes not found in the fee schedule are priced at submitted charges.
6. XXU05 – The billed service exceeds the UR amount authorized.
7. 93 – No claim level adjustment.
8. P12 - Workers' compensation jurisdictional fee schedule adjustment.
9. 18 – Duplicate claim/service.
10. TX224 – Duplicate charge.
11. N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.

12. N45 – Payment based on authorized amount.
13. P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
14. 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. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for CPT Codes 97799-CP-GP rendered on August 22, 2025. The respondent did not submit a response to this dispute. This decision is therefore based solely on the information available at the time of review.

2. The requester submitted three copies of explanation of benefits (EOB) for review.
    - EOB dated September 12, 2025
        - Payment denied with codes 198, 45, N54 and XXU05 stating services exceeded authorized amount.
    - EOB dated October 13, 2025
        - Payment denied with codes 18 and TX224 stating duplicate claim/service.
    - EOB dated December 18, 2025
        - Payment of $25.00 made and remaining charges reduced with codes N45 stating payment based on authorized amount.

    28 TAC Section 134.600 (p) states, "non-emergency health care requiring preauthorization includes: (10) chronic pain management/interdisciplinary pain rehabilitation…"

    A review of the submitted documents finds a utilization review determination letter from MedInsight's dated August 1, 2025, authorizing 10 sessions/80 hours of chronic pain management program to be provided between the dates of July 31, 2025, through October 30, 2025 using required code 97799.

    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..."

A review of the submitted medical record finds that the medical documentation supports that on the disputed dates of service, the requester rendered 8 units (8 hours) of procedure code 97799 as defined above within the authorized timeframe. Therefore, DWC finds that the insurance carrier's reimbursement reduction is not supported.

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."

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

Date of Service	CPT Code	# Units	Amount in Dispute	IC Paid	MAR $100/Hour	Amount Due
08/22/25	97799-CP-GP	8	$2,400.00	$25.00	$800.00	$775.00

   The total allowable reimbursement for the services in question is $800.00. Zurich American Insurance Company reimbursed $25.00. An additional reimbursement of $775.00 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 Company must remit to Auto & Work Injury Clinic – Daniel Beltran $775.00 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	May 6, 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. 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.