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

Injury Centers of TX

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1842-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 26, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 28, 2025	97799	$960.00	$400.00
July 29, 2025	97799	$960.00	$400.00
July 30, 2025	97799	$960.00	$400.00
July 31, 2025	97799	$960.00	$400.00
August 1, 2025	97799	$960.00	$400.00
August 4, 2025	97799	$960.00	$400.00
August 5, 2025	97799	$960.00	$400.00
August 6, 2025	97799	$960.00	$400.00
August 8, 2025	97799	$960.00	$400.00
August 11, 2025	97799	$960.00	$400.00

September 2, 2025	97799	$960.00	$400.00
September 3, 2025	97799	$960.00	$400.00
September 4, 2025	97799	$960.00	$400.00
September 5, 2025	97799	$960.00	$400.00
September 8, 2025	97799	$960.00	$400.00
September 9, 2025	97799	$960.00	$400.00
September 10, 2025	97799	$960.00	$400.00
September 11, 2025	97799	$960.00	$400.00
September 12, 2025	97799	$960.00	$400.00
September 15, 2025	97799	$960.00	$400.00
	Total	$19,200.00	$8,000.00

Requester's Position

"We believe this claim was submitted correctly and falls within the guidelines of coverage."

Amount In Dispute: $9,600.00

Respondent's Position

"Carrier has previously responded to this dispute on 03/13/2026. We are attaching EOBs dated 03/09/2026 recommending payment for a date of service between 7/28/25 and 08/11/25, in the amount of $4,000 and a date of service between 09/02/05 and 09/15/2025, in the amount of $4,000 plus EOS recommending payment of interest."

Response Submitted By: Flahive, Ogden & Latson

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 134.204 sets out the fee guidelines for chronic pain management.

Adjustment Reasons

The original denials were not maintained after MFDR. The insurance carrier reduced the payments made March 9, 2026 for the disputed services with the following reasons:

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?

2. Did the respondent support payment?

3. Did the requester meet the billing requirements of code 97799?

4. Did the insurance carrier support reduction based on a contract?

5. What rule is applicable to reimbursement?

6. Has DWC determined whether additional reimbursement is due?

Findings

1. The requester is seeking $9,600 for chronic pain management services billed under code 97799 for dates of service from July 28, 2025 through August 11, 2025, and an additional $9,600.00 for services provided from September 2, 205 through September 15, 2025. The total amount requested is $19,200.00.

2. The insurance carrier supports payment made of $8,000.00 on March 9, 2026 plus interest however, the requester still disputes the paid amount.

3. 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 without the CA modifier.

4. Review of the submitted explanation of benefits indicates that the payment reduction was made pursuant to the statement: "This bill was reviewed in accordance with your Coventry contract." However, based on the information available to the Division, the injured worker is not enrolled in a certified network, and insufficient evidence exists to establish a contractual agreement between the parties. Accordingly, the reduction is not supported.

5. 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.

   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 submitted medical bill and the injured worker not being enrolled in a certified network the MAR for each date of service is shown below.

Date of Service	Billed code	Billed amount	MAR $125 X 80% = $100/unit x 8 units	Amount paid by insurance carrier	Amount due to requester
7/28/25	97799-CP	$960.00	$800.00	$400.00	$400.00
7/29/25	97799-CP	$960.00	$800.00	$400.00	$400.00
7/30/25	97799-CP	$960.00	$800.00	$400.00	$400.00
7/31/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/1/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/4/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/5/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/6/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/8/25	97799-CP	$960.00	$800.00	$400.00	$400.00
8/11/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/2/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/3/25	97799-CP	$960.00	$800.00	$400.00	$400.00

9/4/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/5/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/8/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/9/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/10/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/11/25	97799-CP	$960.00	$800.00	$400.00	$400.00
9/12/25	97799-CP	$960.00	$800.00	$400.00	$400.00
TOTAL		**$19,200.00**	**$16,000.00**	**$8,000.00**	**$8,000.00**

6. Based on the available information at the time of review DWC finds the insurance carrier's reduction based on Coventry contract was not supported as insufficient evidence found to support the injured worker is enrolled in a certified health network. The MAR for each date of service is $800. As shown above the amount due to the requester is $8,000.00. 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 additional 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 Injury Centers of Tx $8,000.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		May 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 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.