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

Pride LLC

Respondent Name

Great American Alliance Insurance

MFDR Tracking Number

M4-26-2515-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

May 6, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 15, 2025	97799-CP-CA-GP-GO	$750.00	$0.00
January 6, 2026	97799-CP-CA-GP-GO	$437.50	$0.00
January 7, 2026	97799-CP-CA-GP-GO	$500.00	$0.00
January 8, 2026	97799-CP-CA-GP-GO	$687.50	$0.00
January 14, 2026	97799-CP-CA-GP-GO	$500.00	$0.00
January 15, 2026	97799-CP-CA-GP-GO	$625.00	$0.00
March 10, 2026	97799-CP-CA-GP-GO	$656.25	$0.00
March12, 2026	97799-CP-CA-GP-GO	$531.25	$0.00
March 31, 2026	97799-CP-CA-GP-GO	$750.00	$0.00
April 8, 2026	97799-CP-CA-GP-GO	$812.50	$0.00

April 9, 2026	97799-CP-CA-GP-GO	$687.50	$0.00
April 15, 2026	97799-CP-CA-GP-GO	$687.50	$0.00
April 16, 2026	97799-CP-CA-GP-GO	$625.00	$0.00
March 27, 2026	97799-CP-CA-GP-GO	$102.12	$0.00
	Total	$8,352.12	$0.00

Requester's Position

"Please review attachments as follows:"

Amount In Dispute: $8,352.12

Respondent's Position

"…We are attaching a copy of the requester's health care claim form and bill for the DOS… …On 5/11/26, a check in the amount of … was issued. It remains the Carrier's position that no additional monies are owed."

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 134.230 sets out the reimbursement guidelines for return to work rehabilitation programs.

Adjustment Reasons

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

- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

2. What rule(s) are applicable to reimbursement?

3. Has DWC determined whether additional reimbursement is due to the requester?

Findings

1. The requester submitted medical bills with the code 97799-CP-CA-GP-GO. This code is specific to Return to Work Rehabilitation Programs found in 28 TAC Section 134.230. The denials made by the insurance carrier at the time or original adjudication and reconsideration were not maintained and will not be considered in this review.

   Code 97799 was considered by the respondent and multiple payments made after MFDR.

   Additionally, the requester listed date of service March 27, 2026 for code 97799-CP-CA-GP-GO. The submitted medical bill for this date of service has CPT code 20552 -59. Based on the request for MFDR, there is not a medical bill to support that code 97799-CP-CA-GP-CO in dispute. This date of service will not be considered in this dispute.

   The payments will be reviewed per the applicable fee guideline to determine if additional payment is still due.

2. 28 TAC Section 134.230 states, The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

   (1) 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) 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.

Based on the above and the requester's use of the CP, CA modifiers, the reimbursement will be $125 per hour with units less than one hour being paid in 15 minute increments. Additionally the requester used the GP – Services deliver under an outpatient physical therapy plan of care and GO – Services delivered under an outpatient occupational therapy plan of care are not applicable to these DWC specific codes and will not be considered in this review.

DOS	CPT CODE	# UNITS	MAR	RESPONDENT PAID	AMOUNT DUE
12-15-2025	97799	6	125 x 6 = $750	$750.00	$0.00
1-6-26	97799	3.5	125 x 3 = $375 125÷4 = $31.25 x 2 = $62.50 $375 + $62.50 = $437.50	$437.50	$0.00
1-7-26	97799	4	125 x 4 = $500.00	$500.00	$0.00
1-8-26	97799	5.5	125 x 5 = $625 +62.50 = $687.50	$687.50	$0.00
1-14-26	97799	4	125 x 4 - $500.00	$500.00	$0.00
1-15-26	97799	5	125 x 5 = $625.00	$625.00	$0.00
3-10-26	97799	5.5	$687.50	$31.25 + 687.50 = $718.75	$0.00
3-12-26	97799	4.5	$500 + $62.50 = $531.25	$31.25 + 562.50	$0.00

3-31-26	97799	6	$750	$750.00	$0.00
4-8-26	97799	6.5	$750 + 62.50 = $812.50	$812.50	$0.00
4-9-26	97799	5.5	$687.50	$687.50	$0.00
4-15-26	97799	5.5	$687.50	$687.50	$0.00
4-16-26	97799	5	$625.00	$625.00	$0.00

3. Based on the information available at the time of this review, DWC finds the respondent has paid the MAR for the dates of service in dispute supported by appropriate medical bill submitted with code 97799 -CP -CA -GP -GO. No additional reimbursement is due.

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 not 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 $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 17, 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.