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

General Information

Requester Name

Pride LLC

Respondent Name

XL Insurance America Inc

MFDR Tracking Number

M4-26-2525-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

May 7, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2025	97799-CP-CA-GP-GO	$812.50	$812.50
November 12, 2025	99214	$272.70	$0.00
November 12, 2025	99080-73	$13.50	$0.00
	Total	$1,098.70	$812.50

Requester's Position

"Please review attachments as follows..."

Amount In Dispute: $1,098.70

Respondent's Position

"Firstly, DOS 09/26/2025 was denied as the rendering provider listed in box 31 of the CMS 1500 indicates Timothy Anderson. However, Mr/Dr Anderson does not appear to be overseeing the patient's treatment as he is listed in none of the medical records for this date of service. ...The second DOS was 11/12/2025. This bill was first received with this MDR, not previously. The document

submitted as the proof of timely filing specifically notes the fax transmission failed 01/15/2026, confirming the bill was not submitted."

Response Submitted By: ESIS

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 billing and payment information for return to work rehabilitation programs.

Adjustment Reasons

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

- 2 – This procedure on this date was previously reviewed.
- 18 – Duplicate claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the respondent raise a new issue?
3. Did the requester submit proof of timely submission?
4. What rule(s) are applicable to reimbursement?
5. Has DWC determined whether reimbursement is due to the requester?

Findings

1. The requester seeks reimbursement of chronic pain management for date of service September 26, 2025 billed under code 97799-CP-CA-GP-G0 in the amount of $812.50 and professional medical services for date of service November 12, 2025 in the amount of $286.20. The total amount in dispute is $1,098.70. The insurance carrier denied these

services in full. The insurance carrier's denials will be reviewed per applicable DWC rules and fee guidelines.

2. The respondent states, "…DOS 09/26/2025 was denied as the rendering provider listed in box 31 of the CMS 1500 indicates Timothy Anderson. However, Mr/Dr Andreson does not appear to be overseeing the patient's treatment…"

   Review of the insurance carrier's response found this denial reason or defense raised was not presented to the requestor before the filing of the request for medical fee dispute resolution. 28 TAC Section 133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   Based on the above, the respondent's position statement regarding DOS 9/26/2025 will not be considered in this review. The denial for duplicate was not supported. The disputed date of service will be reviewed according to the applicable fee guideline.

3. The respondent states, "…The document submitted as proof of timely filing specifically notes the fax transmission failed 01/15/2025…" The information submitted with this request indicates "Fax Message Transmission Result to +1 (855) 4965410 – FAILED."

   The respondent's position for date of service November 12, 2025, for code 99214 and 99080 -73 is supported.

   As the requester did not support the timely submission of this medical bill within 95 days of the date of service to the correct workers' compensation carrier no payment is recommended.

4. The reimbursement of Return-to-Work Rehabilitation Programs is found in 28 TAC Section 134.230(1)(A) and 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).

28 TAC Section 134.230(5)(A)(B) 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 the submitted medical bill indicates on date of service September 26, 2025, 6.5 units were billed under code 97799. The reimbursement calculation is shown below.

- 125 x 6 = $750.00
- 125 ÷ 4 = $31.25 x 2 = $62.50
- Total allowable - $812.50

5. Based on the information available at the time of this review, DWC finds that the respondent did not support the denial set forth in its position statement. The denial was not reflected on an Explanation of Benefits (EOB) and, therefore, was not considered. Accordingly, the allowable amount for the date of service September 26, 2025, is $812.50.

   The respondent's position statement regarding the medical bill for the date of service November 12, 2025, is supported. The evidence submitted by the requester indicates that the fax transmission was unsuccessful. Therefore, no payment is recommended for this date of service.

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 XL Insurance Company must remit to Pride, LLC $812.50 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	June 23, 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.