



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Occufit

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-25-0109-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

September 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 10, 2024	97546-WH	\$294.40	\$0.00
June 12, 2024	97546-WH	\$294.40	\$0.00
June 13, 2024	97546-WH	\$294.40	\$0.00
Total		\$883.20	\$0.00

Requestor's Position

"Our office received an explanation of review for date of services: 06/10/2024-6/13/2024 however, based on explanation codes; P12/P13 (workers compensation jurisdictional fee schedule adjustment) Code 97546-WH reimbursement is across the board the same and as previously paid at \$307.20 and not \$12.80. There is not a valid explanation code for the reduction of the services."

Amount in Dispute: \$883.20

Respondents' Position

The Austin carrier representative for Insurance Co of the State of PA is Flahive, Ogden & Latson. Flahive, Ogden & Latson was notified of this medical fee dispute on September 24, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.
3. [28 TAC §134.230](#) sets out medical fee guidelines for Return-to-Work Rehabilitation programs.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 93 – No claim level adjustments.
- 18-3 – Exact duplicate claim/service.
- B13-1 – Previously paid, payment for this claim/service may have been provided in a previous payment.
- TX224 – Duplicate charge.

Issues

1. Did the insurance carrier support the denial reason P13?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for an additional 6 hours billed under CPT code 97546-WH and rendered on June 10, 2024, June 12, 2024, and June 13, 2024. A review of the explanation of benefits finds that the insurance carrier issued a partial payment of \$12.80 for

each disputed date of service and reduced the remaining charges with code P13 (description provided above).

The requestor billed with CPT code 97546-WH, modifier "CA" was not appended to the disputed CPT code. Therefore, the requestor provided a non-CARF accredited work hardening service.

28 TAC §134.230, sets out the fee guidelines for work hardening services.

28 TAC §134.230 (1) (A) states, "Accreditation by the CARF is recommended, but not required. (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 §134.230 (3)(A)(B), states, "For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier. (B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 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.

A review of the documentation provided by the requestor finds the insurance carrier provided no documentation to support the denial reason "P13." The disputed charges are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks additional reimbursement for work hardening services provided on June 10, 2024, June 12, 2024, and June 13, 2024. The insurance carrier issued a partial payment and denied the remaining charge with denial reason codes P13 (description listed above). Because the insurance carrier's denial reasons are not supported, the requestor is entitled to reimbursement pursuant to the applicable rules and guidelines.

A review of the medical bill finds that the requestor billed 6 units of CPT code 97546-WH, to indicate that an additional 6 hours were rendered on the disputed dates of service.

A review of the medical documentation finds the following.

- Date of Service (DOS) June 10, 2024 the requestor documented, 15 minutes for treadmill walking, 10 minutes for walking, 15 minutes for airdyne cycle and 10 minutes for upper extremity cycle. Although the requestor indicates the start and end time, with a total of 480 minutes, the requestor did not identify the service rendered for each additional hour of time billed under CPT code 97546.
- DOS, June 12, 2024 the requestor documented 15 minutes, treadmill walking, 10 minutes for walking, 20 minutes for airdyne cycle, 15 minutes for upper extremity cycle, and 10 minutes for stair stepping/walking. Although the requestor indicates the start and end time, with a total of 480 minutes, the requestor did not identify the service rendered for each additional hour of time billed under CPT code 97546.

- DOS, June 13, 2024 the requestor documented 15 minutes, treadmill walking, 10 minutes treadmill jogging, 20 minutes for walking, 10 minutes for airdyne cycle, 15 minutes upper extremity cycle, and 10 minutes stair stepping/walking. Although the requestor indicates the start and end time, with a total of 480 minutes, the requestor did not identify the service rendered for each additional hour of time billed under CPT code 97546

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has not established that additional reimbursement is due. As a result, the requester is entitled to \$0.00 for the disputed services.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to an additional payment of \$0.00 for the services in dispute.

Authorized Signature

		January 8, 2025
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 §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, call CompConnection at 1-800-252-7031, option 3 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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1\(d\)](#).

Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.