



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Genco

Respondent Name

AIU Insurance Company

MFDR Tracking Number

M4-25-0992-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 7, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|-------------------|-------------------|-------------------|-----------------|
| November 4, 2024 | 97546 WH 59 | \$497.20 | \$0.00 |
| November 5, 2024 | 97546 WH 59 | \$497.20 | \$0.00 |
| November 6, 2024 | 97546 WH 59 | \$497.20 | \$0.00 |
| November 7, 2024 | 97546 WH 59 | \$497.20 | \$0.00 |
| November 11, 2024 | 97546 WH 59 | \$497.20 | \$0.00 |
| November 12, 2024 | 97546 WH 59 | \$497.20 | \$294.40 |
| November 13, 2024 | 97546 WH 59 | \$497.20 | \$294.40 |
| December 9, 2024 | 97546 WH 59 | \$497.20 | \$294.40 |
| Total | | \$3,977.60 | \$883.20 |

Requestor's Position

"Several claims were short paid. DATE OF SERVICE 11-04-2024 through 12-09-2024."

Amount in Dispute: \$3,977.60

Respondents' Position

"We have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

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:

- 130 - Consult plan benefit documents/guidelines for information about restrictions for this service.
- 45 - Payment based on authorized amount.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- P13 - Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only no other code is applicable.
- W3 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.
- 00663 - Reimbursement has been calculated based on the state guidelines
- XU03 - The billed service was reviewed by UR and authorized.
- 93 - No claim level adjustment
- 18 - Duplicate claim/service
- 18 - Exact duplicate claim/service.
- 51 - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.

Issues

1. Has the insurance carrier issued payment for the work hardening service in accordance with 28 TAC §134.230?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester seeks reimbursement for an additional 6 hours of work hardening billed under CPT code 97546-WH 59 and rendered on ten different dates from November 4, 2024, through December 9, 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 denial codes listed above. After reconsideration, the insurance carrier made additional payments of \$294.40 for dates of service November 4, 2024, November 5, 2024, November 6, 2024, November 7, 2024, and November 11, 2024.

The requester billed with CPT code 97546-WH, modifier "CA" was not appended to the disputed CPT code. Therefore, the requester 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.

An examination of MedInsight's preauthorization dated October 29, 2024, reveals that 80 hours of work hardening with a start date of October 29, 2024, and an end date of January 29, 2025, were approved. The division determines that the disputed services were provided within the preauthorized timeframes, and no evidence was discovered to justify that the requester exceeded the preauthorized 80 hours. As a result, the requester is eligible for reimbursement.

2. A review of the medical bill finds that the requester billed 2 hours under CPT code 97545-WH, which is not in dispute, and 6 hours of CPT code 97546-WH. The requester billed \$510.00 for 6 hours of CPT code 97546-WH, a non-CARF accredited work hardening program. The insurance carrier issued a partial payment of \$12.80 for each disputed date of service, and the requester seeks an additional payment of \$497.20 for each disputed date of service.

After reconsideration, the insurance carrier made additional payments of \$294.40 for dates of service November 4, 2024, November 5, 2024, November 6, 2024, November 7, 2024, and November 11, 2024.

The MAR for a non-CARF accredited work hardening service is \$51.20. The requestor seeks an additional payment of \$3,977.60 for 48 units of CPT code 97456-WH.

A review of the medical documentation finds the following:

| Date | Service | Units Billed | Documented Hours | Billed | Paid | Disputed | MAR | Amount Due |
|-------------------|------------|--------------|------------------|-------------------|-------------------|-------------------|-------------------|-----------------|
| November 4, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$307.20 | \$497.20 | \$307.20 | \$0.00 |
| November 5, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$307.20 | \$497.20 | \$307.20 | \$0.00 |
| November 6, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$307.20 | \$497.20 | \$307.20 | \$0.00 |
| November 7, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$307.20 | \$497.20 | \$307.20 | \$0.00 |
| November 11, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$307.20 | \$497.20 | \$307.20 | \$0.00 |
| November 12, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$12.80 | \$497.20 | \$307.20 | \$294.40 |
| November 13, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$12.80 | \$497.20 | \$307.20 | \$294.40 |
| December 9, 2024 | 97546 - WH | 6 | 6 | \$510.00 | \$12.80 | \$497.20 | \$307.20 | \$294.40 |
| TOTAL | | 48 | 48 | \$4,080.00 | \$1,574.40 | \$3,977.60 | \$2,457.60 | \$883.20 |

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement of \$883.20 is due. As a result, the requester is entitled to \$883.20 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 established that additional reimbursement of \$883.20 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement. It is ordered that the respondent must submit to the requestor \$883.20 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 11, 2025

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