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

General Information

Requestor Name
Marcus P. Hayes

Respondent Name
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-25-1198-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 4, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2024	97546 – WH x 6	$204.80	$166.40
November 19, 2024	97546 – WH x 6	$204.80	$0.00
November 20, 2024	97546 – WH x 6	$204.80	$12.80
November 21, 2024	97546 – WH x 6	$204.80	$0.00
November 22, 2024	97546 – WH x 6	$204.80	$12.80
November 25, 2024	97546 – WH x 6	$204.80	$64.00
November 26, 2024	97546 – WH x 6	$204.80	$0.00
December 3, 2024	97546 – WH x 6	$204.80	$89.60
December 4, 2024	97546 – WH x 6	$204.80	$12.80
December 5, 2024	97546 – WH x 6	$204.80	$0.00
	Total	$2,048.00	$358.40

Requestor's Position

"The Hartford did not pay CPT 97546 correctly. Per the TAC 134.230 calculation is applied to determine MAR for 6 hours (6 units) of CPT 97546-WH rendered by a non-CARF accredited payment should be $307.20 rather than $102.40. It is my opinion that The Hartford is acting in bad faith on issuing any additional pay amount for the specific date range, as all medical supporting documentation were submitted."

Amount in Dispute: $2,048.00

Respondents' Position

"The bill was processed and paid per max number of units allowed according to fee schedule and or service code description. Also, the billing procedure code has exceeded the National Correct Codding [sic] Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. CPT 97546 maximum at 2 units."

Response Submitted by: The Hartford Financial Services Group, Inc.

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.
4. 28 TAC §134.204(a)(5) sets out medical fee guidelines for Workers' Compensation Specific Services
5. 28 TAC §19.2005 sets out the standards of utilization review.

Denial Reasons

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

- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 -Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 -Bill is a reconsideration or appeal.
- 193 -Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 225 - The recommended allowance is based on a PPO contract held with your facility.
- 309 -The charge for this procedure exceeds the fee schedule allowance.
- P12 -Workers' compensation jurisdictional fee schedule adjustment.
- 1115 -We find the original review to be accurate and are unable to recommend any additional allowance.
- 3244 -The billing of the procedure code has exceeded the national correct coding initiative medically unlikely edits amount for the number of times this procedure can be billed on a date of service. An allowance has not been paid.
- 133 -The disposition of this claim/service is pending further review.
- 600 -Allowance based on maximum number of units allowed according to the fee schedule and/or service code description or regulations.
- PPRJ -Paid without prejudice.

Issues

1. Is the insurance carrier's denial due to NCCI medically unlikely edits supported?
2. Has the insurance carrier issued payment for the work hardening services in accordance with 28 TAC §134.230?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester seeks reimbursement for work hardening services billed under CPT code 97546-WH and rendered on ten different dates from November 18, 2024, through December 5, 2024.

   The insurance carrier states in pertinent part, "… the billing procedure code has exceeded the National Correct Codding [sic] Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. CPT 97546 maximum at 2 units."

   28 TAC §134.204(a)(5) states "Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

   Utilization Review decisions regarding medical necessity made in accordance with Labor Code §413.031, which are made on a case-by-case basis, take precedence in that case over Medicare payment policies. Because the services in dispute are preauthorized, the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement pursuant to 28 TAC §134.230.

2. The requester seeks reimbursement for an additional 4 hours of work hardening billed under CPT code 97546-WH and rendered on ten different dates from November 18, 2024, through December 5, 2024. A review of the explanation of benefits finds that the insurance carrier issued a partial payment of $102.40 for each disputed date of service and reduced the remaining charges with denial codes listed above.

3. 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 medical bills finds that the requestor billed 2 units of CPT code 97545-WH and 6 units of CPT code 97546-WH. The insurance carrier issued a payment in full for 2 units of CPT code 97545-WH, the requester is therefore not disputing this CPT code.

   The insurance carrier issued a payment for 2 units of CPT code 97546-WH and the requester seeks an additional payment for 4 units of CPT code 97546-WH.

   A review of the medical documentation finds the following.

DOS	CPT x 6 Units	Total Documented Time	Total Units Paid	Units Due	MAR/Hour (Unit) non-CARF / $51.20	MAR/Each 15 min non-CARF / $12.80	MAR Total	Requested Amt.	Amt. Due
11/18/24	97546 – WH	7h:20m		3.20	$51.20 x 3 = $153.60	$12.80 x 1 = $12.80	$166.40	$204.80	$166.40
11/19/24	97546 – WH	2h:40m	4	0	$0.00	$0.00	$0.00	$204.80	$0.00
11/20/24	97546 – WH	4h:20m	4	0.20	$0.00	$12.80 x 1 = $12.80	$12.80	$204.80	$12.80
11/21/24	97546 – WH	2h:40m	4	0	$0.00	$0.00	$0.00	$204.80	$0.00
11/22/24	97546 – WH	4h:20m	4	0.20	$0.00	$12.80 x 1 = $12.80	$12.80	$204.80	$12.80
11/25/24	97546 – WH	5h:10m	4	1.10	$51.20 x 1 = $51.20	$12.80 x 1 = $12.80	$64.00	$204.80	$64.00
11/26/24	97546 – WH	2h:40m	4	0	$0.00	$0.00	$0.00	$204.80	$0.00
12/03/24	97546 – WH	5h:40m	4	1.40	$51.20 x 1 = $51.20	$12.80 x 3 = $38.40	$89.60	$204.80	$89.60
12/04/24	97546 – WH	4h:20m	4	0.20	$0.00	$12.80 x 1 = $12.80	$12.80	$204.80	$12.80
12/05/24	97546 – WH	2h:40m	4	0	$0.00	$0.00	$0.00	$204.80	$0.00
				Totals:	**$256.00**	**$102.40**	**$358.40**	**$2,048.00**	**$358.40**

   The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement is due. As a result, the requester is entitled to $358.40 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 $358.40 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 remit to the requestor $358.40 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 14, 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 electronico CompConnection@tdi.texas.gov.