



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated Healthcare

**Respondent Name**

Old Republic Insurance Co

**MFDR Tracking Number**

M4-25-1353-01

**Carrier's Austin Representative**

Box Number 44

**DWC Date Received**

February 19, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 26, 2024	97545-WH	\$0.00	\$0.00
November 26, 2024	97546-WH	\$89.60	\$89.60
November 27, 2024	97545-WH	\$0.00	\$0.00
November 27, 2024	97546-WH	\$89.60	\$89.60
December 2, 2024	97545-WH	\$0.00	\$0.00
December 2, 2024	97546-WH	\$89.60	\$38.40
December 3, 2024	97545-WH	\$0.00	\$0.00
December 3, 2024	97546-WH	\$89.60	\$89.60
December 5, 2024	97545-WH	\$0.00	\$0.00
December 5, 2024	97546-WH	\$89.60	\$89.60
<b>Total</b>		<b>\$448.00</b>	<b>\$396.80</b>

## Requestor's Position

"This bill was denied full payment stating 'workers compensation jurisdictional regulations'. This is incorrect and all other bills have been paid in full for authorized work harding services. This too should be paid in full."

**Amount in Dispute:** \$448.00

## Respondents' Position

"Our bill audit company has determined that no further payment is due. The rationale for this determination is below. DOS: 11/26/2024 – 12/05/2025 Rationale: Fee Schedule has determined the allowable for each Date of Service is correct."

**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:

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- N45 – Payment based on authorized amount.
- N130 – Consult plan benefit documents/guidelines for information about restrictions for this service.
- P12 -Workers' compensation jurisdictional fee schedule adjustment.
- TX350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- XXG15 – Pricing is calculated based on the medical professional fee schedule value.

- 00663-1 – Reimbursement has been calculated based on the state guidelines.
- 93 – No claim level adjustments.

### **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 1.75 hours work hardening billed under CPT code 97546-WH and rendered on five different dates from November 26, 2024, through December 5, 2024. A review of the explanation of benefits finds that the insurance carrier issued a partial payment of \$115.20 for each disputed date of service and reduced the remaining charges with denial codes listed 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.

The insurance carrier reduced payment for CPT code 97546-WH with denial reduction code "N45 – Payment based on authorized amount." A review of the submitted documentation finds that the requestor billed for the first two units of a work hardening program, under CPT code 97545-WH and 2 additional hours under CPT code 97546-WH.

An examination of Medinsights preauthorization dated October 28, 2024, reveals that 80 hours of work hardening with a start date of October 28, 2024, and an end date of January 28, 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 requestor is eligible for reimbursement.

2. A review of the medical bills finds that the requester billed for a non-CARF accredited work hardening program. The first two hours were billed under the CPT code 97545-WH and reimbursed in full by the insurance carrier. Therefore, the first two hours are not in dispute. The requestor billed an additional 9 hours under CPT 97546-WH. The insurance carrier issued a partial payment of \$12.80 for each disputed DOS. The requestor seeks an additional payment of \$448.00.

A review of the medical documentation finds the following:

Date	Service	Units Billed	Documented Hours	Billed	Paid	Disputed	MAR	Amount Due
November 26, 2024	97546-WH	2	2	\$102.40	\$12.80	\$89.60	\$102.40	\$89.60
November 27, 2024	97546-WH	2	2	\$102.40	\$12.80	\$89.60	\$102.40	\$89.60
December 2, 2024	97546-WH	1	1	\$51.20	\$12.80	\$89.60	\$51.20	\$38.40
December 3, 2024	97546-WH	2	2	\$102.40	\$12.80	\$89.60	\$102.40	\$89.60
December 5, 2024	97546-WH	2	2	\$102.40	\$12.80	\$89.60	\$102.40	\$89.60
<b>TOTAL</b>		<b>9</b>	<b>9</b>	<b>\$460.80</b>	<b>\$64.00</b>	<b>\$448.00</b>	<b>\$460.80</b>	<b>\$396.80</b>

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement of \$396.80 is due. As a result, the requester is entitled to an additional payment of \$396.80 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 \$396.80 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 \$396.80 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 28, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).