



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Marcus P. Hayes, DC

Respondent Name

Old Republic Insurance Company

MFDR Tracking Number

M4-25-2479-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

June 6, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 2, 2025	97546 - WH	\$294.40	\$256.00
April 3, 2025	97546 - WH	\$294.40	\$12.80
April 8, 2025	97546 - WH	\$294.40	\$166.40
April 9, 2025	97546 - WH	\$294.40	\$102.40
April 10, 2025	97546 - WH	\$294.40	\$12.80
April 14, 2025	97546 - WH	\$294.40	\$102.40
Total		\$1,766.40	\$652.80

Requester's Position

"The reconsideration for CPT Code 97546 was labeled 'NOT A DUPLICATE' & 'This is a request for reconsideration', they have processed the reconsideration incorrectly as duplicate. It is in my opinion that Gallagher Bassett is acting in bad faith on issuing the correct pay amount for the specific date range, as all medical supporting documentation was submitted. We ask that you review carefully and advise payment to be issued accordingly."

Amount in Dispute: \$1,766.40

Respondents' Position

The Austin carrier representative for Old Republic Insurance Company is White Espey Plc. White Espey Plc was notified of this medical fee dispute on June 9, 2025. 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 §134.230](#) 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:

- 151 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- P13 – Payment reduced or denied based on the 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.
- 18 – Exact duplicate claim/service.
- TX224 – Duplicate charge.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- 93 – No claim level adjustment.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.

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 is seeking additional reimbursement for CPT code 97546-WH, which was provided on six dates between April 2, 2025, and April 14, 2025. According to the explanation of benefits, the insurance carrier issued a payment of \$102.40 for CPT code 97545-WH on each of the dates in question. However, the requester does not dispute payment for the two units billed under that code, and therefore those charges are not considered in this review.

For CPT code 97546-WH, the insurance carrier issued a partial payment of \$12.80 per date of service and denied the remaining charges using the following denial code:

- 151 – *"Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."*

To support their request, the provider submitted a preauthorization report from MedInsights dated February 24, 2025, which approved 10 eight-hour sessions, totaling 80 hours. The documentation confirms that the services provided did not exceed the authorized eight-hour limit per session.

The Division of Workers' Compensation (DWC) finds that the carrier's denial based on reason code 151 is not supported by the documentation provided.

Additionally, the disputed charges were also partially denied under the following codes:

- N45 – *"Payment based on authorized amount."*
- N130 – *"Consult plan benefit documents/guidelines for information about restrictions for this service."*

Upon review, the Division found no evidence of a contractual agreement between the parties or a mutually agreed-upon authorized payment amount. Therefore, the carrier's reductions are also found unsupported.

2. The requester billed CPT code 97546-WH for the disputed dates of service. However, the "CA" modifier was not appended to the code, indicating that the services were provided under a non-CARF-accredited work hardening program.

In accordance with 28 TAC §134.230, the fee guidelines for work hardening services are as follows:

§134.230(1)(A)-(B) states:

Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) is recommended but not required. For non-CARF-accredited programs, only the appropriate program modifier (e.g., "WH") is required. Reimbursement for these services is set at 80% of the Maximum Allowable Reimbursement (MAR).

§134.230(3)(A)-(B) further clarifies:

For Division purposes, Comprehensive Occupational Rehabilitation Programs (as defined in the CARF manual) are considered work hardening. The first two hours of each session are to be billed and reimbursed as one unit using CPT code 97545 with modifier "WH." Each additional hour should be billed using CPT code 97546 with modifier "WH." For CARF-accredited programs, the "CA" modifier must also be added.

Reimbursement is set at \$64 per hour, with units of less than one hour prorated in 15-minute increments. A single 15-minute unit may be billed if it is at least 8 minutes but less than 23 minutes in duration. Based on these guidelines, the following section provides a detailed reimbursement calculation for each of the disputed dates of service:

DOS	CPT x 6 Units	Total # Units Doc. Including 97545-WH	# Units Paid	# Units Due	Non-CARF MAR 1 Hr. Unit \$51.20	Non-CARF MAR 15 min Unit \$12.80	Non-CARF MAR Total	Requested Amt.	Amt. Due
04/02/25	97546 – WH	7.25	2.25	5.00	\$51.20x5= \$256.00	\$0.00	\$256.00	\$294.40	\$256.00
04/03/25	97546 – WH	2.50	2.25	0.25	\$0.00	\$12.80x1= \$12.80	\$12.80	\$294.40	\$12.80
04/08/25	97546 – WH	5.50	2.25	3.25	\$51.20x3= \$153.60	\$12.80x1= \$12.80	\$166.40	\$294.40	\$166.40
04/09/25	97546 – WH	4.25	2.25	2.00	\$51.20x2= \$102.40	\$0.00	\$102.40	\$294.40	\$102.40
04/10/25	97546 – WH	2.50	2.25	0.25	\$0.00	\$12.80x1= \$12.80	\$12.80	\$294.40	\$12.80
04/14/25	97546 – WH	4.25	2.25	2.00	\$51.20x2= \$102.40	\$0.00	\$102.40	\$294.40	\$102.40
Totals:					\$614.40	\$38.40	\$652.80	\$1,766.40	\$652.80

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement of \$652.80 is due. As a result, the requester is entitled to \$652.80 for the disputed services.

Conclusion

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

The DWC finds the requester has established that additional reimbursement of \$652.80 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement. It is ordered that the respondent must remit to the requester \$652.80 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

September 9, 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.