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

General Information

Requester Name
Peak Integrated Healthcare

Respondent Name
Service Llyod's Insurance Co

MFDR Tracking Number
M4-25-2530-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
June 11, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 17, 2024	99213	$185.89	$0.00
October 17, 2024	99080-73	$15.00	$0.00
September 26, 2024	99361-W1	$113.00	$0.00
October 22, 2024	97750-GP	$557.52	$416.77
November 19, 2024	97545-WH	$102.40	$102.40
November 19, 2024	97546-WH	$102.40	$102.40
November 26, 2024	97545-WH	$51.20	$51.20
November 26, 2024	97546-WH	$102.40	$102.40
December 2, 2024	97545-WH	$51.20	$38.40
December 2, 2024	97546-WH	$102.40	$0.00
December 19, 2024	97545-WH	$102.40	$0.00
December 19, 2024	97546-WH	$102.40	$89.60
December 30, 2024	97545-WH	$102.40	$0.00
December 30, 2024	97546-WH	$102.40	$89.60
December 5, 2024	97545-WH	$102.40	$0.00
December 5, 2024	97546-WH	$102.40	$89.60
December 12, 2024	97545-WH	$102.40	$0.00
December 12, 2024	97546-WH	$102.40	$89.60
	Total	$2202.61	$1,082.37

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated January 30, 2025 and June 11, 2025 that states, …These bills should be paid in full we were authorized and approved treatment for a compensable injury and continue to be paid for treatment for this same injury."

Supplemental response July 29, 2025

"Please continue the dispute. We have not been paid."

Amount in Dispute: $2202.61

Respondent's Position

"This payment has been processed in accordance with the Medical Fee Dispute Resolution findings."

Supplemental response

"I've complete the investigation regarding the MDR inquiry. After speaking with Michelle from Service Insurance, I can confirm:

Payment Status:

- No new payment was issued
- All appropriate payments were previously processed to the provider prior to MFDR request.
- The issued letter provide complete documentation including (attached):
    - Bill numbers
    - Paid amounts
    - Check numbers
    - Payment dates

Denial information:

- 3 bills were denied due to UR (Utilization Review) denial
- 1 bills was denied as a duplicate of a previously processed and paid bill.

Response submitted by: Enlyte

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.230 sets out the guidelines for return to work rehabilitation programs.

3. 28 TAC §133.240 sets out the requirements of medical payments and denials.

4. 28 TAC §134.225 sets out the reimbursement guidelines for functional capacity evaluations.

5. 28 TAC §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- G15 – Pricing is calculated based on the Medical Professional Fee Schedule Value
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- U03 – The billed service was reviewed by UR and authorized.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – This bill has been identified as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- U02 – The billed service was reviewed by UR and denied.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- U05 – The billed service exceeds the UR amount authorized.

Issues

1. What rule(s) is applicable to reimbursement for work hardening services?
2. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
3. What rule is applicable to reimbursement of code 97750-FC?
4. Are the insurance carrier's denial for lack of authorization supported?
5. Is the requester entitled to additional payment?

Findings

1. The requester seeks reimbursement for professional medical services rendered from September 26, 2024, until December 30, 2024. The insurance carrier submitted evidence of payment or denial in their response to MFDR. All services except those on October 22, 2024, November 19, 2024 and November 26, 2024 received payment. These services are reviewed below.

   Regarding Codes 97546-WH and 97545-WH. The DWC Rule that applies to reimbursement is

found in 28 TAC §134.230 (1) (B) that states, The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

(1) 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**.

DWC Rule 28 TAC §134.230 (3) 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 8 minutes and less than 23 minutes.

Review of the information available at the time of this review indicates the requestor is Non-CARF accredited. Therefore, the reimbursement rate of $64 is reduced by 80% to equal $51.20 per unit. Code 97545 has a MAR of $102.40. Code 97546 has a MAR of $51.20 per unit billed. Additionally, the requester submitted evidence to support the number of units found below for the codes 97545 and 97546.

Date of Service		CPT	Units	Amount billed	Carriers adjudication	MAR	Amount due
September 26, 2024		99361-W1 Med Conf	1	$0.00	Carrier paid $113.00 via check # 14852476 November 11, 2024	$113.00	$0.00
October 17, 2024		99213	1	$185.89	Carrier paid $185.89 via check # 14852476 November 11, 2024	$185.89	$0.00
October 17, 2024		99080-73	1	$15.00	Carrier paid $15.00 check # 14852476 November 11, 2024	$15.00	$0.00

October 22, 2024		97750-GP	8	$557.52	Carrier denied stating billed service was reviewed by UR and denied.	See below	
November 19, 2024		97545-WH	1	$102.40	Carrier denied stating authorization exceeded	See below	
November 19, 2024		97546-WH	2	$102.40	Carrier denied stating authorization exceeded	See below	
November 26, 2024		97545-WH	1	$102.40	Carrier denied stating authorization exceeded	See below	
November 26, 2024		97546-WH	1	$51.20	Carrier denied stating authorization exceeded	See below	
December 2, 2024		97545-WH	1	$102.40	Carrier paid $102.40 via check 285632 on December 10, 2024	MAR $51.20 X 2 = $102.40	$0.00
December 2, 2024		97546-WH	1	$51.20	Carrier paid $12.80 via check 285632 on December 10, 2024	MAR $51.20 X 1 = $51.20	$38.40
December 19, 2024		97545-WH	1	$102.40	Carrier paid $102.40 December 31, 2024	MAR $51.20 X 2 = $102.40	$0.00
December 19, 2024		97546-WH	2	$102.40	Carrier paid $12.80 December 31, 2024	MAR $51.20 X 2 = $102.40	$89.60
December 30, 2024		97545-WH	1	$102.40	Carrier paid $102.40 December 31, 2024	MAR $51.20 X 2 = $102.40	$0.00
December 30, 2024		97546-WH	2	$102.40	Carrier paid $12.80 December 31, 2024	MAR $51.20 X 2 = $102.40	$89.60
December 5, 2024		97545-WH	1	$102.40	Carrier paid $102.40 December 30, 2024	MAR $51.20 X 2 = $102.40	$0.00
December 5, 2024		97546-WH	1	$102.40	Carrier paid $12.80 December 30, 2024	MAR $51.20 X 2 = $102.40	$89.60
December 12,		97545-	1	$102.40	Carrier paid $102.40	MAR $51.20 X 2	$0.00

2024		WH			December 30, 2024	= $102.40	
December 12, 2024		97546-WH	2	$102.40	Carrier paid $12.80 December 30, 2024	MAR $51.20 X 2 = $102.40	$89.60
						Total due	$396.80

2. The requester rendered services billed under code 97750-FC on date of service October 22, 2024. The insurance carrier denied the claim stating the service was reviewed by UR and denied.

   DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, "When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title …, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..." Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q).

   Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute, and this denial reason will not be considered in this review.

3. The applicable fee guideline for FCEs is found at 28 TAC §134.225, which states, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test unless it is the initial test. Documentation is required. "

   DWC Rule 28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Medicare Claims Processing Manual Chapter 5, 10.7-effective June 6, 2016, titled Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services, states in pertinent part:

   > Full payment is made for the unit or procedure with the highest PE payment….
   >
   > For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and

malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

On the disputed date of service, the requester billed CPT code 97750-FC x 8 units.

As seen above, the multiple procedure discounting rule applies to the disputed service.

The MPPR Rate file that contains the payments for 2024 services are found at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

To determine the MAR the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- MPPR rates are published by carrier and locality.
- Disputed service was rendered in zip code 75043, locality 04411 11, Garand, Tx.
- The disputed date of service is October 22, 2024.
- The MPPR rate for CPT code 97750 in 2024 at this locality is $33.65 for the first unit, and $24.42 for each subsequent unit.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor is 33.2875
- 67.81/33.2875 x $33.65 = $68.55
- 67.81/33.2875 x 24.42 x 7 = $348.22
- Total MAR is $416.77

4. The insurance carrier denied the Work Harding services on November 19, 2024 and November 26, 2024 as exceeding authorization. The information submitted with this request for MFDR included a "genex" Review #6663810 with UR Determination "Recommend prospective request for 1 work hardening program for the left shoulder (80 hours) between 10/24/2024 and 2/22/2025 be certified. This documentation does not support that for the time period in dispute the certified 80 hours of work hardening had been exceeded.

   The November 19, 2024 medical bill indicates.

   - 97546 WH 2 units. The reimbursement rate of $64 is reduced by 80% to equal $51.20 per unit x 2 units = $102.40
   - 97545 WH 1 unit. Code 97546 has a MAR of $51.20 per unit billed.

   The November 26, 2024 medical bill indicates.

- 97546 WH 1 unit. The reimbursement rate of $64 per unit billed.
- 97545 WH 1 unit. Code 97546 has a MAR of $51.20 per unit billed.

The total MAR for the November 19, 2024 and November 26, 2024 services are $153.60 and $115.20 for a total of $268.80.

5. The requester sought reimbursement for professional medical services with dates of service ranging from September of 2024 through December 2024. The insurance carrier submitted evidence of payment and denials in support of their position that no additional payment was due. Review of the information submitted by DWC found the payment made by the insurance carrier on code 97546 -WH was not a MAR and additional payment ordered. The denial for utilization review was not supported. The MAR for the functional capacity evaluation was ordered per MAR and the denial for November work hardening charges was not supported. These services were ordered per MAR.

    - The additional payment to reach MAR for 97546-WH is $396.80
    - The recommended payment for the functional capacity is $416.77
    - The recommended payment for November work hardening is $268.80
    - Total recommended payment is $1082.37.

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.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Service Lloyd's Insurance Co must remit to Peak Integrated Health Services $1082.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 24, 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, please 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.