TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
GENCO

Respondent Name
AIU Insurance Company

MFDR Tracking Number
M4-25-3035-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 10, 2024	97546 WH 59	$475.40	$281.60

Requester's Position

"The first 2 hours are billed as one unit at $170.00 this was entered correctly at insurance and actually paid correctly by insurance. The remaining 6 hours of program were billed at 6 units (1 unit per hour). The correct allowable according to TDI DWC rules is $64.00 per hour for the additional 6 hours of program. I have attached a copy of the rule for your reference."

Amount in Dispute: $475.40

Respondents' Position

"Our bill audit company has determined that additional monies are owed in the amount of $230.40. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records. We are requesting the dispute be withdrawn."

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 §134.230 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:

- N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.
- N45 - 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 if 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.
- 93 - No claim level adjustment.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- Q01 – Additional allowance recommended, this has been re-evaluated and an additional allowance is recommended.
- U03 – The billed service was reviewed by UR and authorized.
- 18 – Exact duplicate claim/service.
- TX224 – Duplicate charge.

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 59, which was provided on December 10, 2024. According to the explanation of benefits, the insurance carrier issued two payments of $102.40 for CPT code 97545-WH for the date 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.

   The requester billed with CPT code 97546-WH 59, 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.

   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 found to be unsupported.

   An examination of the 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.

After reconsideration, the insurance carrier made two payments of $12.80 for the date of service, for a total payment of $25.60.

The MAR for a non-CARF accredited work hardening service is $51.20. The requester seeks an additional payment of $475.40 for 6 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
December 10, 2024	97546 - WH	6	6	$510.00	$25.60	$475.40	$307.20	$281.60

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement of $281.60 is due. As a result, the requester is entitled to $281.60 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 $281.60 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 $281.60 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	November 26, 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.