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

General Information

Requester Name
Workers Clinic Inc.
Daniel Beltran, D.C.

Respondent Name
United Wisconsin Insurance Company

MFDR Tracking Number
M4-25-3242-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
August 11, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Findings
January 15, 2025	97545-WH-GP	$360.00	$102.40
January 15, 2025	97546-WH-GP	$450.00	$256.00
	Total	**$810.00**	**$358.40**

Requester's Position

"Upon review, we have determined that the diagnoses should be limited exclusively to the..., as this is the only area related to the treatment provided on the above date. Therefore, we have updated the attached CMS-1500 form with the appropriate, specific, and billable ... diagnosis codes."

Amount in Dispute: $810.00

Respondent's Position

"We are upholding our original denial due to service denied as body part is not accepted as part of this claim."

Response Submitted by: CompIQ Solutions

Findings and Decision

Authority

This medical fee dispute is dismissed pursuant to 28 Texas Administrative Code §133.307 (f)(3) 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 denied the payment for the disputed services with the following claim adjustment codes:

- NLA105 - Service denied as body part is not accepted as part of the claim.
- CIQ378 - This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
- W3 - TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.
- N-1 - Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line: $0;
- 148 – This procedure on this date was previously reviewed.
- 18 – Exact duplicate claim/service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- EOB22 – Upheld, no additional allowance has been recommended.

Issues

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason?
2. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for 7 hours work hardening billed under CPT codes 97545-WH-GP and 97546-WH-GP. The insurance carrier denied the disputed services with denial code "NLA105 - Service denied as body part is not accepted as part of the claim".

   28 TAC §133.307(d)(2)(H), "Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requester in the form and manner prescribed by the division… (H) If the medical fee dispute involves compensability, extent of injury, or liability, the

insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements)."

Review of the documentation submitted by the parties, finds that the carrier did not provide documentation to the Division to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H).

The Division of Workers' Compensation (DWC) finds that the respondent did not provide sufficient information to the Medical Fee Dispute Resolution (MFDR) section to demonstrate that the PLN was ever presented to the requester or that the requester was otherwise informed of the PLN prior to the date the request for medical fee dispute resolution was filed. Accordingly, the DWC concludes that the denial of extent of injury was not timely communicated to the requester.

As there is no unresolved extent of injury issue associated with the disputed service, this matter is eligible for adjudication of a medical fee under 28 TAC §133.307. Therefore, it will be resolved in accordance with the applicable rules and guidelines.

2. The requester billed with CPT code 97545-WH-GP and 97546-WH-GP, modifier "CA" was not appended to the disputed CPT codes. As a result, the services rendered are considered a non-CARF accredited work hardening program. Accordingly, the disputed services are reviewed pursuant to 28 TAC §134. 230.

   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 Ascential Care Partners' preauthorization dated December 16, 2024, confirms approval for 80 hours of work hardening with a start date of December 12, 2024, and an end date of March 12, 2025. The division finds that the insurance carrier's denial is unsupported. The disputed services were rendered within the authorized timeframe, and there is no evidence to support that the requester exceeded the approved 80 hours. Therefore, the requester is entitled to reimbursement.

   A review of the medical bill indicates that the requester billed 2 hours under CPT code 97545-WH-GP and 5 hours under CPT code 97546-WH-GP, totaling 7 hours. The total amount billed for the non-CARF accredited work hardening program is $810.00 per date of service. The

Maximum Allowable Reimbursement (MAR) for a non-CARF accredited work hardening service is $51.20 per hour.

A review of the medical documentation finds the following:

Date	Service	Units Billed	Hours Recorded	Billed	Paid	Disputed	MAR Amount Due
January 15, 2025	97545-WH	2	2	$360.00	$0.00	$360.00	$102.40
January 15, 2025	97546-WH	5	5	$450.00	$0.00	$450.00	$256.00
TOTAL		**7**	**7**	**$810.00**	**$0.00**	**$810.00**	**$358.40**

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that reimbursement of $358.40 is due.

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 reimbursement of $358.40 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement. It is ordered that the respondent must remit to the requester $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	October 10, 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.