



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Robert Zuniga DC

Respondent Name

Sentinel Insurance Company LTD

MFDR Tracking Number

M4-25-3345-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

August 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 7, 2025	97546 WH	\$204.80	\$204.80
April 9, 2025	97546 WH	\$204.80	\$204.80
April 11, 2025	97546 WH	\$204 80	\$204 80
April 14, 2025	97546 WH	\$204 80	\$204 80
April 15, 2025	97546 WH	\$204.80	\$204.80
April 16, 2025	97546 WH	\$204.80	\$204.80
April 17, 2025	97546 WH	\$204.80	\$204.80
April 21, 2025	97546 WH	\$204 80	\$204 80
April 22, 2025	97546 WH	\$204.80	\$204.80
April 24, 2025	97546 WH	\$204.80	\$204.80
Total		\$2,048.00	\$2,048.00

Requester's Position

"Our office received an explanation of review for date of service 04/07 /2025- 04 /24 /2025 however, according to the explanation of benefits: 309 (procedure exceeds the fee schedule allowance) 600 (allowance based on maximum number of units allowed according to the fee schedule) P12(workers compensation fee schedule). Pre-authorization was obtained; please see the letter attached. Authorization#: ... authorizing 80 hours of work hardening. 97546 WH- paid incorrectly at \$102.40."

Amount in Dispute: \$2,048.00

Respondents' Position

"The original bill for dos 4/7-4/24/25 was received on 5/9/25 under control number The bill was processed per fee schedule and maximum number of units allowed per verified timed codes in the medical reports. Paid 5/23/25 in the amount is \$2048.00."

Response Submitted by: The Hartford

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:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 600 – Allowance based on the maximum number of units allowed according to the fee schedule and/or service code description or regulations.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

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 ten dates between April 7, 2025, to April 24, 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 \$102.40 per date of service and denied the remaining charges using the following denial codes:

- 309 – *“The charge for this procedure exceeds the fee schedule allowance.”*
- 600 – *“Allowance based on the maximum number of units allowed according to the fee schedule and/or service code description or regulations.”*

To support their request, the provider submitted a preauthorization report from The Hartford dated April 3, 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 309 and 600 is not supported by the documentation provided.

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.	# Units Previously Paid	# Units Due	MAR/Hour (Unit) Non-CARF / \$51.20	Non-CARF MAR Total	Requested Amt.	Amt. Due	
<i># Units Previously Paid: 97545 x 2 paid, 97546 x 2 paid</i>					<i>Total paid per DOS = 4 units</i>				
04/07/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/09/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/11/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/14/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/15/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/16/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/17/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/21/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/22/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
04/24/25	97546 – WH	8	4	4	\$51.20x4= \$204.80	\$204.80	\$204.80	\$204.80	
Totals:					\$2,048.00	\$2,048.00	\$2,048.00	\$2,048.00	

The division finds that pursuant to 28 TAC §134.230 (3)(A)(B) the requester has established that additional reimbursement of \$2,048.00 is due. As a result, the requester is entitled to \$2,048.00 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 \$2,048.00 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 \$2,048.00 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 17, 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.