

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Peak Integrated Healthcare

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-26-0150-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

September 16, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 17, 2025	97545-WH	\$0.00	\$0.00
July 17, 2025	97546-WH	\$51.20	\$0.00
Total		\$51.20	\$0.00

Requester's Position

"After reconsideration we were denied stating duplicate claim and service and it does not exceed fee allowance."

Amount In Dispute: \$51.20

Respondent's Position

"The bill related to the above captioned MDR has been reprocessed and payment was made 8/15/2025 and no interest was due."

Response Submitted By: ESIS, Inc.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.230](#) sets out the medical fee guidelines for Return-to-Work Rehabilitation programs.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 1 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (222)
2. 2 – Work hardening (452)
3. P12 – Workers compensation jurisdictional fee schedule adjustment.
4. 4 – A technical Bill Review (TBR) has been performed. (ETBR).
5. 1- Original DCN [redacted]
6. 2 – This procedure on this date was previously reviewed. (146)
7. 18 – Duplicate claim/service. (ANSI18)

Issues

1. What is DWC considering in this medical fee dispute?
2. Has the insurance carrier issued payment for the work hardening service in accordance with 28 TAC Section 134.230?
3. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional payment of \$51.20 for CPT Code 97546-WH for date of service July 17, 2025. The insurance carrier reduced payment stating, "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." The requester is seeking \$0.00 for 97545-WH; therefore, this service is not considered in this dispute.
2. The documentation reflects that CPT Code 97546-WH was billed without modifier "CA." As a result, the services are considered non-CARF accredited work hardening services.

3. A review of the submitted documentation finds that the requester billed two units of a non-CARF accredited work hardening service. The documentation submitted for review indicates that the insurance carrier issued a reduced payment of \$51.20(one unit) for CPT Code 97546-WH on August 15, 2025.

The applicable rules and guidelines are as follows:

28 TAC Section 134.230 sets out the fee guidelines for work hardening services.

28 TAC Section 134.230(1)(A)–(B) states that CARF accreditation is recommended but not required. If a program is not CARF accredited, the only required modifier is the appropriate program modifier, and reimbursement is limited to 80% of the Maximum Allowable Reimbursement (MAR)."

4. 28 TAC Section 134.230(3)(A)–(B) provides that:

- (a) Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered work hardening for Division purposes.
- (b) The first two hours of each session are billed under CPT Code 97545-WH as one unit.
- (c) Each additional hour is billed under CPT Code 97546-WH.
- (d) CARF-accredited programs must append modifier "CA."
- (e) Reimbursement is \$64 per hour, with time prorated in 15-minute increments. A single 15-minute increment may be billed if the service duration is eight minutes or greater but less than 23 minutes.

The requester submitted a document titled "Work Hardening / Work Conditioning / Chronic Pain Management" dated October 21, 2022. This document contains illegible sections, including column headings with dates (October 21, 2022) unrelated to the disputed date of service.

Encounter notes date July 17, 2025, state: "Number of hours completed today: On this day 7/17/2025 this patient completed 36 of 80 hours of work hardening program". However, the documentation does not sufficiently support the billing or reimbursement sought for CPT Code 97546-WH on the disputed date.

28 TAC Section 133.307(c) requires that requests for Medical Fee Dispute Resolution be legible and filed in the form and manner prescribed by the Division.

DWC finds that the documentation submitted is insufficient to support additional reimbursement for CPT Code 97546-WH for date of service July 17, 2025. Therefore,

additional reimbursement is not recommended.

Conclusion

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

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	February 3, 2026
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 Section [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 800-252-7031, option three 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 this Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.