



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FOOT SOLUTIONS

Respondent Name

TASB RISK MGMT FUND

MFDR Tracking Number

M4-10-2369-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

AUGUST 31, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Elizabeth Johnson insurance would not pay unless client had shoes first. Gave her the shoes, did not receive payment unless July. Does not agree with amount due to business does not work off fee schedule, expect full balance. DDIS for (fee schedule) cover cost of one pair of shoes."

Amount in Dispute: \$294.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|---|-------------------|------------|
| May 4, 2009 | DME Items – HCPCS Code L3400-RT-LT Metatarsal bar wedge, rocker | \$294.68 | \$89.84 |
| | DME Items – HCPCS Code L3221 Orthopedic footwear, mens shoe, depth inlay, each | | |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B22-Carrier has disputed arthropathy, tendonopathy, prior fib tip fracture as not part of the compensable injury.
 - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does a compensability, extent or liability issue exist in this dispute?
2. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to additional reimbursement for HCPCS codes L3400 and L3221?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "B22." The Division finds that upon reconsideration, the respondent paid \$185.32 for the disputed services; therefore, the respondent did not maintain this denial and a compensability, extent or liability issue does not exist in this dispute.
2. 28 Texas Administrative Code §133.307(c)(2)(A) states "a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills)." A review of the submitted documentation finds that the requestor did not submit a copy of the original or reconsideration bill in the dispute packet; therefore, the dispute was not filed in the form and manner required by 28 Texas Administrative Code §133.307(c)(2)(A).
3. Because the requestor did not submit any medical bills for review the Division relied on the explanation of benefits and the Table of Disputed Services to determine the services in dispute. The requestor lists on the Table of Disputed Services codes L3400 and L3221 for a total amount paid of \$185.32. According to the explanation of benefits, the requestor was reimbursed for L3400-RT and L3400-LT at \$92.66 each for a total of \$185.32 and \$0.00 for code L3221. Further review of the explanation of benefits finds that the amount billed was \$0.00 for code L3221. Therefore, the total MAR will be based upon two units of L3400 and one unit of L3221.

Per 28 Texas Administrative Code §134.203(d) "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The 2009 DMEPOS fee schedule finds that HCPCS code L3400 has a fee of \$37.07; therefore, per 28 Texas Administrative Code §134.203(d), the MAR is $\$37.07 \times 125\% = \46.33 . Per the explanation of benefits, the requestor billed two units, thus $2 \times \$46.33 = \92.66 .

The 2009 DMEPOS fee schedule finds that HCPCS code L3221 has a fee of \$146.00; therefore, per 28 Texas Administrative Code §134.203(d), the MAR is $\$146.00 \times 125\% = \182.50 .

The total allowance for the disputed services is \$275.16. The respondent paid \$185.32. As a result, additional reimbursement of \$89.84 is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$89.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$89.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

05/30/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.