



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

SAN ANTONIO PROSTHETICS CORP.

Respondent Name

EDINBURG CONSOLIDATED ISD

MFDR Tracking Number

M4-19-0021-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

SEPTEMBER 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "San Antonio Prosthetics, Corporation provided services to [Claimant] after receiving prior authorization in accordance with TAC Rule 134.600(f). Tristar denied the claim payment for most of the billing codes which consist of a knee prosthesis replacement socket to an existing prosthetic limb...the prosthetic socket replacement, liner and additional codes were preauthorized on July 24, 2017."

Amount in Dispute: \$13,620.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier will stand on the denial/reduction of the charge made the basis of this medical fee dispute. Preauthorization was made for Knee prosthesis socket and liner, codes L8410 and L5671. These are the charges that were paid (see EOB attached). The other line items were not preauthorized and are therefore not eligible for reimbursement."

Response Submitted by: Dean G. Pappas, PLLC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2017	HCPCS Code L5701	\$3,937.00	\$0.00
	HCPCS Code L5950	\$1,141.00	\$0.00
	HCPCS Code L5695	\$476.00	\$259.93
	HCPCS Code L5624	\$533.00	\$0.00
	HCPCS Code L5649	\$2,672.00	\$0.00
	HCPCS Code L5650	\$655.00	\$0.00
	HCPCS Code L5651	\$1,756.00	\$0.00

September 2, 2017	HCPCS Code L5673	\$1,612.00	\$0.00
	HCPCS Code L5631	\$670.00	\$0.00
	HCPCS Code L5671	\$0.00	\$0.00
	HCPCS Code L8460	\$168.00	\$91.87
	HCPCS Code L8410	\$0.00	\$0.00
TOTAL		\$13,620.00	\$351.80

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
 - 39-Services denied at the time authorization/pre-certification was requested.

Issues

1. Does a preauthorization issue exist in this case?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed DME based upon a lack of preauthorization.

The respondent wrote, "Preauthorization was made for Knee prosthesis socket and liner, codes L8410 and L5671. These are the charges that were paid (see EOB attached). The other line items were not preauthorized and are therefore not eligible for reimbursement."

The basis for the respondent's position is found at 28 Texas Administrative Code §134.600(p)(9).

Per 28 Texas Administrative Code §134.600(p)(9), "Non-emergency health care requiring preauthorization includes: 9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)."

The requestor contends that reimbursement is due because preauthorization was obtained for the DME services. In support of the position a copy of the preauthorization report from Tristar dated July 24, 2017 was submitted for review.

The division finds the preauthorization report authorized "knee prosthesis socket and liner purchase. L8410, L5671."

Based upon the submitted documentation, the division finds:

- The requestor supported preauthorization was obtained for HCPCS codes L8410 and L5671.
- Per 28 Texas Administrative Code §134.600(p)(9), any DME service in dispute that was billed at a charge over \$500.00 required preauthorization; therefore, reimbursement is not due for HCPCS code L5701, L5950, L5624, L5649, L5650, L5651, and L5673.
- Per 28 Texas Administrative Code §134.600(p)(9), the requestor did not charge over \$500.00 for codes L5695 and L8460; therefore, these services did not require preauthorization and reimbursement is due.

2. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(d)(1-3) states “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.”

HCPCS CODE	DMEPOS FEE SCHEDULE	MAR	IC PAID	DUE
L5695	\$207.95	\$259.93	\$0.00	\$259.93
L8460	\$73.50	\$91.87	\$0.00	\$91.87

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 \$351.80.

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 \$351.80 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

11/07/2018
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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