TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEDICAL CENTER HEARING AIDS, LTD

Respondent Name
PETROLEUM CASUALTY COMPANY

MFDR Tracking Number
M4-19-1091-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for review.

Amount in Dispute: $3,832.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Medicaid requires the health care provider to be, reimbursed 'the lesser of the max fee, invoice or acquisition cost.' HCPCS code V5253 does not have an established fee schedule amount…. paid based on the invoice …. which shows the cost of the binaural hearing aids to be $1070 each (left and right). Total reimbursement for HCPCS code V5253 was $1070 x 2 + a 20% markup = $2568."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 25, 2018	Professional Medical Services	$3,832.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Charge Included in another Charge or Service.
   - P12 – Workers' Compensation State Fee Schedule Adj.
   - ORC – See Additional Information
   - P5 – Based on payor reasonable/customary fees
   - 18 – Duplicate Claim/Service
   - R1 – Duplicate Billing

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards audiology services and hearing aid equipment provided to an injured employee. The *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203, requires the maximum allowable reimbursement (MAR) be determined by Medicare payment policies modified by DWC rules; however, Medicare has not assigned a relative value or payment for the disputed audiology services or hearing aid products.

While Rule §134.203(d) addresses Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L, it does not address HCPCS Level II V codes.

Rule §134.203(f) requires that for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d), or the Division, reimbursement shall be provided in accordance with Rule §134.1. The division notes that, although Texas Medicaid assigns a fee to code V5266, this is not a product addressed in Rule §134.203(d) — the Medicaid fee is thus not applicable to HCPCS V codes.

Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), requiring that reimbursement shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

Rule §134.1(f) specifies that fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;
(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
(3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Rule §133.307(c)(2)(N) requires the requestor to provide a position statement of the disputed issues, including:

(i) the requestor's reasoning for why the disputed fees should be paid or refunded,
(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
(iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

Rule §133.307(c)(2)(O) further requires that when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or rate, the requestor shall provide: documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Rule §134.1.

Review of the submitted documentation finds the requestor did not submit a position statement for review, nor did the requestor provide documentation discussing, demonstrating or justifying that the payment amount sought is a fair and reasonable rate of reimbursement in accordance with Rule §134.1

The division finds insufficient information to support the requested payment amount. Consequently, no additional reimbursement can be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	November 30, 2018
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 in accordance with Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.