



# 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**

HOLMES PROSTHETIC CENTER

**Respondent Name**

ZURICH AMERICAN INSURANCE COMPANY

**MFDR Tracking Number**

M4-20-2834-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 3, 2020

**Response submitted by:**

J. Diamond and Associates, PLLC

### **REQUESTOR'S POSITION SUMMARY**

"On July 26, 2019 HPC received authorization for a replacement prosthesis with the reasons noted. Reference #3401008. We then fit and fabricated a new prosthesis for [injured employee]. It was delivered to him and billed to the insurance company on September 12, 2019. On October 8, 2019 HPC received a denial for billed services with the reason of Absence of Precertification/ Authorization. We followed up with a call to his adjustor, Mae Robinson. She explained the carrier did not feel liable and responsible for [injured employee's] new prosthesis. She informed us that we should make arrangements with [injured employee's] to pay out of pocket for the prosthesis. She said she would inform [injured employee's] of this... On November 12, 2019 we received a second denial also for the reason of Absence of Precertification/ Authorization. Finally, we were advised to file this DWCO60 with the TDI."

### **RESPONDENT'S POSITION SUMMARY**

"...the medical fees associated with the health care services/equipment made the basis of this dispute were incurred to replace a prosthesis that [injured employee] lost in the process of riding a jet ski on July 4, 2019. As such, the medical fees related to fitting and fabricating a new replacement prosthesis were neither related to [injured employee's] compensable injury, nor reasonable, nor necessary for the treatment of [injured employee's] compensable injury. But for losing the prosthetic, which was purchased relatively recently (10/04/18) prior to it being lost, no medical treatment or services would be required—the prosthetic did not need to be replaced due to wear and tear, and nothing changed physically on the part of [injured employee] which required adaptation of, or revision to, the prosthetic itself. As such, the above-referenced Medical Fee Dispute should be dismissed."

### **SUMMARY OF DISPUTED SERVICE(S)**

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
September 11, 2019	DME-Prosthesis	\$146,817.93	\$54,097.08

### **FINDINGS AND DECISION**

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

## **Background**

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.203, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION .
  - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
  - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED . UPON REVIEW, IT WAS
  - 5264 – PAYMENT IS DENIED-SERVICE NOT AUTHORIZED.
  - 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED
  - 96 – NON-COVERED CHARGE(S).
  - 5718 – CARRIER IS NOT LIABLE FOR REPLACEMENT OF THE LOST DME

## **Issue(s)**

1. Does the insurance carrier's position statement address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor submit documentation to support that preauthorization was obtained?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for HCPCS Code L5999?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor seeks reimbursement for a prosthesis rendered on September 11, 2019. The insurance carrier denied/reduced the disputed service(s) on the explanation of benefits with denial reduction code(s), "197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION" and "5264– PAYMENT IS DENIED-SERVICE NOT AUTHORIZED". In the respondent's position statement submitted after they had received the medical fee dispute; they argue that the disputed service was not related to the compensable injury. They state in part: "In fact, the health care services/ equipment at issue was not provided to treat [injured employee's] compensable injury. Specifically, the medical fees associated with the health care services/equipment made the basis of this dispute were incurred to replace a prosthesis that [injured employee] lost, in the process of riding a jet ski on July 4, 2019. As such, the medical fees related to fitting and fabricating a new replacement prosthesis were neither related to [injured employee's] compensable injury, nor reasonable, nor necessary for the treatment of [injured employee's] compensable injury."

28 TAC §133.307(d)(2)(F) states " The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

The insurance carrier raises the issue of relatedness and treatment of compensable injury. However, they did not include a copy of a PLN11 disputing either one.

28 TAC §133.307 (H) states, "(H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements)."

Therefore, the DWC concludes that the respondent has waived the right to raise additional denial reasons or defenses. Any new denial reasons or defenses shall not be considered in this review.

2. The insurance carrier denied the services for lack of preauthorization. 28 TAC §134.600 sets out the guidelines for preauthorization in the Texas Workers' Compensation system.

28 TAC §134.600(p) states "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)." Some of the services in dispute are DME in excess of \$500 and required preauthorization.

28 TAC §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

The requestor submitted a copy of a preauthorization letter issued by Sedgwick, dated July 25, 2019. The letter indicates the following:

"Specific Request: DME above knee prosthesis (IC suction socket, flex frame, seal in liner, sitting rotator, X3 MPK knee, triton foot, Silesian belt) x 99 months for left knee/ Medically certified by Physician Advisor."

The reference # provided is 3401008 with a start date of July 17, 2019 and an end date of 10/17/19. The respondent's denial reasons are not supported. The disputed services are listed below:

HCPCS CODE	HCPCS DESCRIPTION	PREAUTH OBTAINED	NO PREAUTH	BILLED CHARGES
L5321	Above knee (AK), molded socket, open end, SACH foot, endoskeletal system, single axis knee	X		\$4,783.52
L5624	Addition to lower extremity, test socket, above knee (AK)	X		\$1,205.28
L5631	Addition to lower extremity, above knee (AK) or knee disarticulation, acrylic socket	X		\$713.37
L5649	Addition to lower extremity, ischial containment/narrow M-L socket	X		\$3,020.67
L5980	All lower extremity prostheses, flex-foot system	X		\$4,775.48
L5650	Additions to lower extremity, total contact, above knee (AK) or knee disarticulation socket	X		\$712.19
L5651	Addition to lower extremity, above knee (AK), flexible inner socket, external frame	X		\$1,990.68
L5705	Custom shaped protective cover, above knee (AK)		X	\$1,190.58
L5920	Addition, endoskeletal system, above knee (AK) or hip disarticulation, alignable system		X	\$879.53
L5950	Addition, endoskeletal system, above knee (AK), ultra-light material (titanium, carbon fiber or equal)		X	\$1,289.65
L5652	Addition to lower extremity, suction suspension, above knee (AK) or knee disarticulation socket	X		\$632.35
L5673	Addition to lower extremity, below knee (BK)/above knee (AK), custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	X		\$1,821.58
L8430	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control	Preauth not required		\$340.56
L5986	All lower extremity prostheses, multiaxial rotation unit (MCP or equal)	X		\$831.66
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control		X	\$3,510.77
L5845	Addition, endoskeletal knee-shin system, stance flexion feature, adjustable	X		\$2,253.20
L5848	Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability		X	\$1,351.77
L5930	Addition, endoskeletal system, high activity knee control frame		X	\$4,231.27
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing, and stance phase, includes electronic sensor(s), any type	X		\$30,177.67
L5999	Lower extremity prosthesis, not otherwise specified	No MAR (Fair & Reasonable)		\$80,000
L5984	All endoskeletal lower extremity prostheses, axial rotation unit, with or without adjustability	X		\$835.82
L5695	Addition to lower extremity, above knee (AK), pelvic control, sleeve suspension, neoprene or equal, each	Preauth not required		\$270.33

The division finds the preauthorization was obtained for the following:

- Above knee prosthesis (IC suction socket
- flex frame
- seal in liner
- sitting rotator
- X3 MPK knee
- triton foot
- Silesian belt) x 99 months for left knee

Based upon the submitted documentation, the division finds that the requestor supported that preauthorization was obtained for the items identified above. As a result, the requestor is entitled to reimbursement for these items.

The billed charge for HCPCS Codes L8430 x 12 and L5695 was below \$500. DME with billed amounts less than \$500 do not require preauthorization, therefore reimbursement is due for L8430 and L5695.

Based on the submitted documentation, preauthorization was not obtained for HCPCS Codes L5650, L5920, L5950, L5828, L5848 and L5930. The requestor is not entitled to reimbursement for these items.

3. The requestor billed HCPCS code L5999, which is defined as "Lower extremity prosthesis, not otherwise specified." Review of the CMS website did not assign a value to this DME code. Additionally, review of the Texas Medicaid fee schedule shows no value assigned for code L5999. Per TAC §134.203(d)(3) if a code has no published Medicare or Texas Medicaid rate then the MAR shall be calculated according to subsection (f) of this section.

28 TAC §134.203(f) states "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 §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 TAC §134.1 (e)(3) states, in pertinent part, "(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with... (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

28 TAC §134.1 (f) states, "(f) 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."

The DWC made a request for additional documentation on September 4, 2020, to support fair and reasonable reimbursement for HCPCS Code L5999 with a billed amount of \$80,000.00. The requestor was provided with 14-days to submit the additional documentation. On September 5, 2020, the requestor submitted a letter providing a description of the miscellaneous code. The letter also included a note indicating the 2020 Manufacturer Suggested Retail Price (MSRP) for the L5999 Adaptive MP feature as \$115,000. The documentation did not discuss, demonstrate, and justify that the payment amount sought, is a fair and reasonable rate of reimbursement. The DWC finds that the documentation submitted by the requestor was insufficient and did not meet the minimum requirements set out in 28 TAC §134.1 (f). As a result, reimbursement cannot be recommended for HCPCS Code L5999.

4. The fee guidelines for professional services are found in 28 TAC §134.203.

28 TAC §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."

For those services preauthorized or not requiring preauthorized the reimbursement amount is set out in the below table:

DOS	HCPCS CODE	MPFS	MAR	AMT IN DISPUTE	AMT DUE
9/11/19	L5321	\$3,805.67	\$4,757.09	\$4,783.52	\$4,757.09
9/11/19	L5624 X 2	\$958.88	\$1,198.60	\$1,205.28	\$1,198.60
9/11/19	L5631	\$579.44	\$724.30	\$713.37	\$713.37
9/11/19	L5649	\$2,403.18	\$3,003.98	\$3,020.67	\$3,003.98
9/11/19	L5980	\$3,878.93	\$4,848.66	\$4,775.48	\$4,775.48
9/11/19	L5650	\$566.61	\$708.26	\$712.19	\$708.26
9/11/19	L5651	\$1,583.74	\$1,979.67	\$1,990.68	\$1,979.67
9/11/19	L5652	\$503.08	\$635.10	\$632.35	\$632.35
9/11/19	L5673 X 2	\$1,449.22	\$1,811.52	\$1,821.58	\$1,811.52
9/11/19	L8430 X 12	\$270.96	\$338.64	\$340.56	\$338.64
9/11/19	L5986	\$661.66	\$827.07	\$831.66	\$827.07
9/11/19	L5845	\$1,792.60	\$2,240.11	\$2,253.20	\$2,240.11
9/11/19	L5856	\$24,008.73	\$30,010.91	\$30,177.67	\$30,010.91
9/11/19	L5984	\$664.96	\$831.20	\$835.82	\$831.20
9/11/19	L5695	\$215.07	\$268.83	\$270.33	\$268.83
<b>TOTAL</b>		<b>\$43,342.73</b>	<b>\$54,183.94</b>	<b>\$54,364.36</b>	<b>\$54,097.08</b>

5. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of \$54,097.08.


**Conclusion**


For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$54,097.08.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of \$54,097.08 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

  
 \_\_\_\_\_  
 Signature Medical Fee Dispute Resolution Officer June 15, 2021  
 \_\_\_\_\_  
 Date

  
 \_\_\_\_\_  
 Signature Director, Medical Fee Dispute Resolution June 15, 2021  
 \_\_\_\_\_  
 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 TAC §133.307, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR 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 DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 TAC §141.1(d).

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