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
AUSTIN BIONICS LLC

Respondent Name
TCSIGA FOR DEAN HOLDING COMPANY

MFDR Tracking Number
M4-21-0438-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
November 13, 2020

Response submitted by:
Parker & Associates, L.L.C.

REQUESTOR'S POSITION SUMMARY

"Total bill for the custom orthotics was for $406,122.08 retail ($284,285.46 expected amount) and partial payment of $90,571.76 was received from Broadspire on 01/22/2020 and $162,492.27 was received on 08/24/2020 from JT Parker & Associates…. Code L8499 (Luke Arm Electronic-Transradial Luke Arm Configuration) has zero value in SFS for this geo zip and was billed as cost plus 25% as per our contract with Broadspire approved by Broadspire Claims Adjuster… We are disputing short payment on Code l8499 (Luke Arm Electronic-Transradial Luke Arm Configuration), bill charge of $267,857.14 retail (x.70% = $187,500.00 expected amount) Less payment from Broadspire and JT Parker."

RESPONDENT'S POSITION SUMMARY

"Accordingly, Parker & Associates engaged Review Med to evaluate the charges in order to calculate the amount due. There are three unlisted procedures for miscellaneous prosthetic services shown on the invoice from Priority Care Solutions, Inc. to Broadspire, as provided by Requestor. Review Med recommended payment at fee schedule for all of the charges except the unlisted codes, for which it recommended payment at fee schedule for all of the charges except the unlisted codes, for which it recommended payment at cost plus ten percent (10%), or $249,994.04. the total recommended on Review Med's EOB was $159,422.28, as Broadspire had previously paid $90,571.76, leaving a recommended balance to be paid of $159,422.28. In addition to this amount, Parker & Associates paid interest in the amount of $3,069.99, for a total of $162,492.27. payment was made on August 20, 2020."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
November 14, 2019	L8499 Luke Arm Electronic-Transradial Luke Arm Configuration	$31,221.43	$0.00

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, effective March 1, 2008, 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:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - P12 – Workers Compensation jurisdictional fee schedule adjustment
   - 350 – Bill has been identified as a request for reconsideration or appeal
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - W3 – In accordance with the TDI-DWC Rule 134.804. This bill has been identified as request for reconsideration or appeal
   - Note: The line for L8499 with a billed amount of $267,857.14 has a total allowance of $165,000 based on allowing cost plus 10% however, the previous payment of $90,571.76 is being deducted from this line
   - 285 – Please refer to the note above for a detailed explanation of the reduction
   - 309 – The charge for this procedure exceeds the fee schedule allowance

Issue(s)

Did the requestor submit documentation to support fair and reasonable reimbursement for HCPCS Code L8499?

Findings

The requestor seeks additional reimbursement for a custom orthotics rendered on November 14, 2019. The insurance carrier issued two payments to the requestor totaling $159,995.96 and reduced the remaining charges with the denial reason codes indicated above.

The requestor billed HCPCS Code L8499 on November 14, 2019, which is defined as "Unlisted procedure for miscellaneous prosthetic services." 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 L8499. Per TAC §134.203(d)(3) if a code has no published Medicare or Texas Medicaid value 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."

Review of the documentation submitted by the requestor does not discuss, demonstrate, and justify that the additional payment amount being 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 L8499.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		June 10, 2021
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 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.