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
AZALEA ORTHOPEDIC & SPORTS MEDICINE

MFDR Tracking Number
M4-21-1413-01

MFDR Date Received
April 12, 2021

Respondent Name
TRAVELERS INDEMNITY COMPANY

Carrier's Austin Representative
Box Number 05

Response Submitted by:
Travelers

REQUESTOR'S POSITION SUMMARY

"This claim was originally denied on 01/15/2021 stating that an invoice was required for proper payment of code L3999. All supporting documentation including an invoice was submitted to the payor for reprocessing on 01/25/2021. The payor denied this claim again stating the denial was upheld due to no invoice be submitted to the payor. All attached information faxed to the payor 01/25/2021 is included in this dispute request."

RESPONDENT'S POSITION SUMMARY

"The Provider did not submit its purchase invoice either in the request for reconsideration or in this Request for Medical Fee Dispute Resolution. As such, the Provider has submitted no evidence to support additional reimbursement satisfies the fair and reasonable reimbursement standards of Rule 134. l(f)."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 23, 2020	L3999	$100.00	$0.00

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 251 – THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM.
   - 5125 – BASED ON THE DOCUMENTATION RECEIVED, SERVICES BILLED REQUIRE AN INVOICE FOR PROPER PAYMENT CONSIDERATION. PLEASE RE-SUBMIT REQUIRED DOCUMENTATION TO SUPPORT SERVICES.

Issues

1. Does the documentation support the billing of HCPCS Code L3999?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed HCPCS Code L3999. The respondent denied reimbursement based upon reason codes 251 and 5125 (description provided above.)

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   HCPCS code L3999 is defined as "Upper limb orthotic, not otherwise specified."

   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. (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. (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   HCPCS code L3999 does not have a fee listed in the DMEPOS fee schedule.

   HCPCS code L3999 does not have a fee listed in Texas Medicaid fee schedule.

   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, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states 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."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 TAC §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $100.00 for HCPCS code L3999 would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended

3. The DWC finds that the requestor is not entitled to reimbursement for the service in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that 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 Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 21, 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, 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 TAC §141.1(d).

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