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
ORTHOTEXAS PHYSICIANS & SURGEONS

Respondent Name
LEWISVILLE ISD

MFDR Tracking
M4-21-2107-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 16, 2021

Response Submitted by:
RM Review Med

REQUESTOR'S POSITION SUMMARY

"HCPSCS [sic] Code A9999 was added to this Date of Service as a corrected claim on 1/12/21, with the description of GenuMotion Knitted Knee Sleeve listed on the cover sheet of our request. The HCPSCS Code A9999 then denied 11/25/21 stating it was not adequately identified. A reconsideration request was mailed 6/17/21 to the carrier listing the description of the item specifically as a 'Jobst Actimove GenuMotion Knee Support #22' in the cover letter to match the wording on the invoice that was also provided exactly. In addition, that same letter stated why we billed this item under HCPCS code A9999 as a Miscellaneous DME Supply item. Our software does not have the HCSPCS code of A4467 in our system. It auto generates when we print the invoice from another software program. Our dispute is that we did provide every effort to identify this item. Both sets of descriptions match the invoice information that was also provided. We believe their denial is in violation of the Texas Administrative Code. Please review all documents submitted."

RESPONDENT'S POSITION SUMMARY

"The service in dispute is A9999 which is a miscellaneous DME code and is a By Report code in the TX WC Fee Schedule. As this code does not have an established reimbursement amount, on our original review we denied this charge and asked the requestor to resubmit with the purchase invoice. We received a reconsideration request; however, the purchase invoice was not submitted. The purchase invoice has not been included with the MFDR documents; therefore, we are still unable to reimburse this charge. Once the requestor submits the purchase invoice, we will proceed with determining the appropriate reimbursement for this miscellaneous DME item. We hope this resolves the dispute at hand."

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2020	A9999	$50.00	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §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:
   - 8 – THE SUPPLY CHARGE W/!S DISALLOWED AS IT WAS NOT AOEQUATELY. IDENTIFIEO. PLEASE RESUBMIT WITH INVOICE.
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.
   - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - P12 – WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENTF

Issue(s)

Is the requestor entitled to reimbursement for the unvalued HCPCS code A9999?

Findings

1. This dispute relates to durable medical services with reimbursement subject to the provisions of 28 TAC §134.1, effective March 1, 2008, 33 *Texas Register* 626, 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."
2. 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.
3. 28 TAC §133.307(c)(2)(N)(i), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not provided a sufficient reason for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(i).
4. 28 TAC §133.307(c)(2)(N)(ii), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not sufficiently discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(ii).
5. 28 TAC §133.307(c)(2)(N)(iii), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor's position for the disputed fee issue." Review of the submitted documentation finds that the requestor has the documentation supports the supports their position for the disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(iii).
6. 28 TAC §133.307(c)(2)(O), applicable to requests filed on or after June 1, 2012, 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:
   - Review of the documentation submitted by the requestor, does not propose a methodology for calculating a fair and reasonable reimbursement,
   - The requestor does not discuss or explain how the documentation, supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed service.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

The DWC finds that the request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 TAC §133.307. The Division further concludes that the requestor failed to support its position 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 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	August 9, 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 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 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 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.