TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-22-1412-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
March 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 16, 2021	L2397	$137.51	$0.00
	Total	$137.51	$0.00

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states in pertinent part, "All necessary and supporting documentation is included with the reconsideration to properly justify/support the administered treatment still needing to be paid."

Amount in Dispute: $137.51

Respondent's Position

CorVel assets the requestor Peak Integrated Healthcare is entitled to $0.00 reimbursement for the durable medical equipment is dispute based on the requestor's failure to substantiate a seperately payable code.

Response submitted by: CorVel

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the reimbursement policies for professional services.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 107 – Denied-qualifying svc not paid or identified

Issues

1. Is the insurance carrier's denial based on qualifying service not identified?

Findings

1. The requestor is seeking reimbursement of HCPCS code L2397 – Addition to lower extremity orthosis, suspension sleeve. The insurance carrier denied as the qualifying service was not paid or identified.

   DWC Rule 134.203 (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.

   Review of the applicable Medicare payment policy at LCD - Knee Orthoses (L33318) (cms.gov), found the disputed code L2397 is an addition code separately payable when provided with a related base code orthosis. The submitted documentation was insufficient to support this add-on code was provided with the related base code.

   The insurance carriers' denial is supported. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		April 11, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.