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
Employers Assurance Co

MFDR Tracking Number
M4-23-0234-01

Carrier's Austin Representative
Box Number 04

DWC Date Received
September 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 30, 2022	L0650	$1173.86	$1173.86
	Total	$1173.86	$1173.86

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a reconsideration that states, "The attached date of service was returned because medical records were needed. All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

Amount in Dispute: $1173.86

Respondent's Position

The Austin carrier representative for Employers Assurance Co is law office of Ricky D Green. The representative was notified of this medical fee dispute on October 4, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available

information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 guidelines for durable medical equipment, prosthetics, orthotics and supplies.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 226 – Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient, incomplete

- 5247 – Please provide chart notes or office notes so we can proceed with the correct payment recommendation

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Is the insurance carrier's denial supported?

2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for an orthotic provided in March of 2022. The insurance carrier denied as request for additional information was not timely, incomplete or insufficient. Insufficient evidence was submitted by the respondent to support what was lacking in the documentation provided by the requestor. The services in dispute will be reviewed per appliable fee guidelines.
2. DWC Rule 28 TAC §134.203 (d) (1) states in pertinent part, "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."

Review of the applicable DMEPOS fee schedule at www.dmepdac.com found the allowable for the disputed date of service is $939.09 this amount multiplied by 125% equals a maximum allowable reimbursement of $1,173.86. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that respondent must remit to requestor $1,173.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 30, 2023
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.