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
Stonington Insurance Co

MFDR Tracking Number
M4-23-1310-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 7, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 29, 2022	E0730, A4595, A4556	$200.87	$67.20
December 29, 2022	E0730, A4595	$114.59	$48.63
	Total	$315.46	$115.83

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "…pre-authorization is not required for this item(s) & it is medically necessary and reasonable, as it was prescribed by the treating doctor per – The Texas Administrative Code Rule 134.600 – any durable medical equipment / DME under $500 – does not need pre-authorization."

Amount in Dispute: $315.46

Respondent's Position

"The provider filed a DWC-60 seeking Medical Fee Dispute Resolution for dates of service of November 29 and December 29, 2022. The services for a TENS unit and leads and electrodes, The carrier disputes that the provider is entitled to reimbursement."

Response submitted by: Flahive, Ogden & Latson

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 Texas Administrative Code §133.307 sets out guidelines for medical fee dispute resolution.

2. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.

3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for durable medical equipment.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P4 – Workers' compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
- W3- Bill is a reconsideration or appeal.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 96 – Non-covered charges.

Issues

1. Did the respondent meet requirements of plain language notice?

2. Are the insurance carrier's reasons for denial or reduction of payment supported?

3. What is the rule applicable to reimbursement?

4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of $315.46 for durable medical equipment provided in November and December 2022. The insurance carrier originally denied the services based on

lack of prior authorization and non-covered service. At reconsideration the insurance carrier added a denial stating the services were non-compensable.

DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The insurance carrier's denial for lack of prior authorization is not upheld. DWC Rule §134.600 (p)(9) indicates all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   Review of the submitted medical bills found the total amount billed was $315.46.

   The insurance carrier's denial for lack of prior authorization is not supported.

3. DWC Rule 134.203(d) 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;

   DWC Rule 134.203 (b) (1) states,

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   Review of the applicable Medicare payment policy found in DME Supplier Manual – Winter 2023 (cgsmedicare.com), "For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10 percent of the average of allowed purchase prices."

The purchase price for Code E0730 is $153.82. One-tenth of the purchase price is $15.38. This amount multiplied by 125% equals $19.22.

The DMEPOS fee schedule allowable amount for Code A4595 is $23.53 multiplied by 125% equals $29.41.

The DMEPOS fee schedule allowable amount for Code A4556 is $14.86 multiplied by 125% equals $18.57.

The total allowed amount for November 29, 2022, is (E0730), $19.22 + (A4595) $29.41 + (A4556) $18.57 = $67.20.

The total allowed amount for December 29, 2022, is (E0730) $19.22 + (A4595) $29.41 = $48.63.

4. The total allowed amount for the services in dispute is $115.83, 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 $115.83 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 15,2023
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.