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
Hartford Lloyds Insurance Co

MFDR Tracking Number
M4-23-1313-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 7, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 19, 2022	E1399	$34.99	$0.00
	Total	$34.99	$0.00

Requestor's Position

The provider did not submit a position statement with their request for MFDR but did submit a copy of their reconsideration that states, "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: $34.99

Respondent's Position

"We reviewed the documentation received on this bill, specifically for billed DME code E1399 for Hot & Cold Pack Wrist Wrap. We found that the original bill denied correctly for lack of supplier's invoice."

Response submitted by: The Hartford

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 set out the billing requirements for durable medical equipment.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

- 3400 – The billed HCPCS code represents a charge for durable medical equipment that is listed in the durable medical equipment fee schedule without a value an invoice showing the cost of the durable medical equipment to the provider should be submitted to assist in determining the correct payment

Issues

1. Did the respondent submit the claim per applicable DWC Rule?

Findings

1. The requestor is seeking reimbursement for a claim billed with HCPCS Code E1399. The description of the item listed on document created by the requestor states, "Elasto- Gel Hot & Cold Pack Wrist Wrap."

   DWC Rule (b) 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 Durable Medical Equipment Coding system at PDAC - DME Coding System (DMECS) Information (dmepdac.com) found based on the description "Gel Hot Cold Pack Wrist Wrap" the applicable HCPCS code is A9273 – Cold or hot fluid bottle, ice, cap or collar, hear and/or cold wrap any type.

Based on DWC review, the requestor did not submit the correct code per applicable rule. 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.

Order

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

Signature	Medical Fee Dispute Resolution Officer	February 28, 2023 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.