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
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-23-2164-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2023	E0730	$167.38	$167.38
January 26, 2023	E0731	$162.93	$162.93
January 26, 2023	E0215	$94.21	$94.21
January 26, 2023	E1399	$35.00	$0.00
	Total	$459.52	$424.52

Requestor's Position

The requestor did not submit a position statement with this request for MFDR but did submit a copy of their reconsideration that states, "Please note item submitted for payment falls within the following guidelines for payment and should be processed for payment immediately, as pre-authorization is not required for this item(s) & it is medically necessary and reasonable, as it was prescribed by the treating doctor…"

Amount in Dispute: $459.52

Respondent's Position

"It remains the carrier's position that preauthorization was required. The provider did not request

preauthorization. The provider is not 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 the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the prior authorization requirements for disputed services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

Denial Reasons

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

- 18 – Exact duplicate claim/service
- 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for durable medical equipment provided in January of 2023. The insurance carrier denied the service for lack of prior authorization.

   DWC Rule TAC §134.600 (p)(9) states (9) "Non-emergency health care requiring preauthorization includes: all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   Review of the submitted documentation found insufficient evidence to support the requirement for prior authorization exists based on medical bill. The insurance carrier's denial is not supported. The disputed services will be reviewed per applicable fee guidelines.

2. DWC Rule 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 125

percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.

The DMEPOS fee schedule amount for the applicable date of service found at www4.palmettogba.com, found the following.

- E0730 -NU - Tens four lead, Texas, $167.38 x 125% = $209.22
- E0731 – Conductive Garment, Texas $162.93 X 125% = $203.66
- E0215 -NU - Electric heating pad, Texas $94.21 x 125% = $117.76
- E1399 – NU. This code is not found on the DMEPOS fee schedule. DWC TAC Rule §134.203 (h)(3) states when there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the fair and reasonable amount consistent with the standards of 134.1 of this title. DWC Rule TAC §134.1 (f)(1)(2)(3) states in pertinent parts, fair and reasonable reimbursement shall be consistent with the criteria of Labor Code §413.011; ensure that similar procedures provided in similar circumstances receive similar reimbursement; and 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.

  Review of the submitted information found insufficient evidence to support the amount requested meets the requirements of fair and reasonable outlined above. No payment is recommended.

3. The MAR for the disputed services as shown above is $530.54. The requestor is seeking $424.52. 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 Starr Indemnity & Liability Co must remit to Peak Integrated Healthcare $424.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 8, 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.