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 Fire Insurance Co.

MFDR Tracking Number
M4-23-2693-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
June 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 5, 2023	A9300	$255.00	$0.00
	Total	$255.00	$0.00

Requestor's Position

"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 medical necessary and reasonable, as it was prescribed by the treating doctor…"

Amount in Dispute: $255.00

Respondent's Position

"We reviewed the bill and documentation submitted for the above claim date of service and find that the original bill was processed correctly as it pertains to A9300. It was processed and denied as the cost of the supply is include in the value of another procedure performed on the same date of service."

Response submitted by: Hartford Fire Insurance Co

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 billing and coding guidelines for durable medical equipment.

Denial Reasons

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

- 7 – The cost of the supply is included in the value of another procedure performed on the same date of service.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of Code A9300 for date of service April 5, 2023. The insurance carrier denied the claim as being included in the primary code.

   DWC Rule TAC §134.203 (b) (1) states in pertinent part, for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment polices, including its coding; billing…"

   Review of the applicable payment policy found this code has a status of "N"- non-covered service. 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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 7, 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.