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
Daniel J Leeman

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-23-3289-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 24, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 29, 2022	V5264	$106.98	$45.39
November 29, 2022	V5160	$300.00	$300.00
	Total	$406.98	$345.39

Requestor's Position

"We have exhausted all efforts with Gallagher Bassett to get these codes paid… This claim was authorized and was billed according to the authorization."

Amount in Dispute: $406.98

Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on August 29, 2023.

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.

Response submitted by: N/A

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §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:

- 5405 – This charge was reviewed through the clinical validation program.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- B13 – Previously paid. Payment for tis claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of $406.98 for professional medical services rendered in November of 2022. The insurance carrier denied the charges as claim lacking information and no maximum allowable defined by legislated fee.

   Review of the submitted DWC60 finds the following two codes in dispute.

   - V5264 – Ear mold/insert, not disposable, any type
   - V5160 – Dispensing fee, binaural

   DWC Rule 28 TAC §134.203(d)(2) states in pertinent part, The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes shall be determined as follows… if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule for HCPCS.

   Centers for Medicare and Medicaid Services (CMS) defines Level II of HCPCS as a standardized coding system that used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

   DWC has determined that insufficient evidence submitted to support that the injured worker is enrolled in a certified health network as stated on the explanation of benefits. The services rendered are within the Level II HCPCS category and while Medicare does not price the disputed codes, Texas Medicaid does.

   The maximum allowable reimbursement is calculated as follows.

   - V5160 – Texas Medicaid Allowable $321.35 x 125% = $401.69
   - V5264 – Texas Medicaid Allowable $36.31 x 125% = $45.39

   DWC Rule 28 TAC §134.203(h)(1)(2) states When there is no negotiated or contracted amount that complies with Labor Code 413.011, reimbursement shall be the least of the MAR amount or health care provider's usual and customary charge…

   Based on the above, the Division finds that the insurance carrier's denials are not supported. The least of the MAR and the provider's charge is.

   - V5160 - $300.00 supplier's charge.
   - V5264 - $45.39 MAR

2. The total allowable for the disputed charges is $345.39. 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 New Hampshire Insurance Co. must remit to Daniel J. Leeman $345.39 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 23, 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.