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
Mitsui Sumitomo Insurance Co of America

MFDR Tracking Number
M4-24-0083-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 18, 2023	E1399	$35.00	$0.00
May 18, 2023	A9300	$340.00	$0.00
	Total	$375.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR.

Amount in Dispute: $375.00

Respondent's Position

The Austin carrier representative for Mitsui Sumitomo Insurance Co of America is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 19, 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 billing and coding guidelines for payment of durable medical equipment.

Denial Reasons

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

- 96 – Non-covered charges.
- R4 – Non-covered procedure per state regulations.
- W3 – Appeal/Reconsideration.
- 510 – Payment determined.
- P5 – Based on payor reasonable/customary fees.

Issues

1. Did the requestor support additional payment for miscellaneous code E1399?

2. What rule is applicable to reimbursement of Code A9300?

Findings

1. The requestor is seeking additional reimbursement of Code E1399. The insurance carrier paid $24.00 for the E1399 Code with a notation "Biofreeze" on September 1, 2023.

   The requestor did not submit a position statement or any documentation to support the requested $35.00. No additional payment is recommended.

2. The requestor is seeking payment for Code A9300 four units – Exercise Equipment.

   DWC Rule 28 TAC §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its code; billing…"

   Review of the Medicare Statue Code indicates Code A9300 is "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

Signature	Medical Fee Dispute Resolution Officer	November 15, 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.