TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
AIU Insurance Co

MFDR Tracking Number
M4-24-0152-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4 2023	E1399	$40.00	$0.00
May 4, 2023	A9300	$340.00	$0.00
	Total	$380.00	$0.00

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, "This item was provided to the patient to help with at home therapy, which is approved by ODG and CMS guidelines."

Amount in Dispute: $380.00

Respondent's Position

"As the Requestor is billing with a POS of 11, this indicates the item was used in the office during treatment and is incidental to the treatment rendered and not separately payable. If the items are provided for home use, DME providers do not bill with POS 11. The Requestor has indicated in reconsideration requests that they are a licensed DME provider and should be paid based on this status as well as indicating that CMS only deems code A9300 as non-covered 'if the patient is bed ridden and runs a risk of entanglement with vital tubes and catheters of any sort.' The

assertion cannot be verified by CMS. . . Code E1399 was not denied as 'non-covered', but rather was denied with CARC 189 (Unlisted code used when valid code available). There is a valid HCPC code for 'Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type.'"

Response submitted by: CorVel

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 §134.203 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:

- 189 - Unlisted code used when valid code available
- 96 – Non-Covered Charges
- R4 – Non-covered procedure per state regulations
- NU – New Equipment
- 97 – Charge Included in another Charge or Service

Issues

1. Are the insurance carrier's reasons for denial supported?

Findings

1. The requestor is seeking reimbursement for durable medical equipment billed under HCPCS codes E1399-NU and A9300, rendered on May 4, 2023. DWC Rule 28 TAC 134.203 states, "(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."

Regarding HCPC E1399 – Durable medical equipment, miscellaneous. Review of the medical bill found a description of "Four Hot/Cold Packs." Review of the DME Coding System (DMECS) at www.dmepdac.com found a HCPCS code that meets this definition.

DWC Rule 28 TAC 134.203(c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." The miscellaneous code submitted does not meet the requirements of correct billing code. No payment is recommended.

Regarding Code A9300. This code has a status code 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 requestor 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

		October 6, 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.