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
Hartford Fire Insurance Co

MFDR Tracking Number
M4-24-0153-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 19, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 19, 2023	A9300 – Exercise Equipment	$255.00	$0.00
April 19, 2023	E0215 – Electric Heat Pad Moist	$94.21	$0.00
April 19, 2023	E0190 – Positioning cushion	$65.00	$0.00
	Total	$414.21	$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, "…pre-authorization IS NOT REQUIRED for this item(s) & it is medically necessary and reasonable, as it was prescribed by the treating doctor per – **The Texas Administrative Code Rule 134.600(P)(12) – any SINGLE ITEM durable medical equipment (DME) under $500 – does NOT need pre-authorization or peer to peer reviews.**"

Amount in Dispute: $414.21

Respondent's Position

"The original bill was processed and paid $146.19 on 5/8/23 under control number 219451244. It was paid per fee schedule with a partial denial as included in the value of another procedure."

Response submitted by: The Hartford

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:

- 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.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B20 – Payment adjusted because procedure/service was partially or fully furnished by another provider.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Are the insurance carrier's reasons for denial supported?
2. What is the rule applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for durable medical equipment billed under HCPCS codes A9300, E0215 and E0190, rendered on April 19, 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 Code A9300. This code has a status code of "N" – Non-covered service. No payment is recommended. Code E0190 is not covered by Medicare in any payment system. The insurance carrier made a payment of $51.98. No additional payment is recommended.

2. Regarding HCPC Codes E0215 – NU, the fee guideline is found at 28 TAC §134.203 (d) which states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   Review of the DMEPOS fee schedule found at www.dmepdac.com. found the following.

   - E0730 non-rural allowable $94.21. This amount multiplied by 125% = $117.76

   DWC Rule TAC §134.203 (h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the **least of the**:

   (1) MAR amount;

   (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount;

   The health care provider's usual and customary charge for E0215 is $94.21. No additional 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

		October 4, 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.