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
Berkshire Hathaway Homestate Insurance

MFDR Tracking Number
M4-24-0474-01

Carrier's Austin Representative
Box Number 12

DWC Date Received
October 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 12, 2023	A9300	$255.00	$0.00
June 12, 2023	E1399	$70.00	$0.00
	Total	$325.00	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR) however, they 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: $325.00

Respondent's Position

"Peak Integrated Healthcare is disputing HCPCS codes A9300 and E1399, These codes are not found on the DMEPOS fee schedule, and they are not payable according to Medicaid. ...Peak Integrated Healthcare failed to submit information to support the amount requested would meet the requirements of fair and reasonable..."

Response submitted by: Berkshire Hathaway Homestate Companies

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.

- 01 (P12) – Additional payment made on appeal/reconsideration.
- @F (W3) – Additional payment made on appeal/reconsideration.
- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- AN (96) – The service is not covered. Medicare payment cannot be made for this service.
- JF (P12) - Documentation submitted does not substantiate the service billed.
- BR (16) – The payment of this service is determined by-report or by a report.
- GP (151) – Based on the code's description, guidelines, anatomical considerations or the nature of service, the maximum number of units of this procedure code has been exceeded for this date of service.

Issues

1. Is the requestor's statement at the time of reconsideration supported?

Findings

1. The requestor is seeking reimbursement of Code E1399 – Durable medical equipment, miscellaneous and A9300 – 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 submitted medical bill found the place of service indicated was "11" in box 24D. This indicates the services were rendered in the physician's office not at home which would have been "12" home.

The requestor's position that these items were for use in a "home" therapy program is not supported by the submitted medical bill.

Additionally the applicable Medicare payment policy for durable medical equipment at www.cms.gov, Claims Processing Manual, Chapter 20, Section 10.1.1 defines DME as equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of an illness or injury; and is appropriate for use in the home.

The "BioFreeze" billed under E1399 does not meet the definition of DME. This code should not have been submitted.

Code A9300 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 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 30, 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.