



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

Richardson ISD

**MFDR Tracking Number**

M4-24-0995-01

**Carrier's Austin Representative**

Box Number 53

**DWC Date Received**

January 10, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2023	E0730	\$167.38	\$0.00
May 30, 2023	E0731	\$162.93	\$0.00
May 30, 2023	E0190	\$55.00	\$0.00
May 30, 2023	E0215	\$94.21	\$0.00
May 30, 2023	E1399	\$35.00	\$0.00
<b>Total</b>		<b>\$514.52</b>	<b>\$0.00</b>

### Requestor's Position

"THE CLAIM ATTACHED WAS INITIALLY DENIED DUE TO NO PRE-AUTH REQUESTED. A RECONSIDERATION WAS SENT WITH LAWS STATING THAT SINGLE DME ITEMS DO NOT REQUIRE PRE-AUTH. THE CARRIER SENT A SECOND DENIAL STATING THE SAME DENIAL AS THE FIRST. WE HAVE ATTACHED PROOF THAT THE FIRST RECONSIDERATION WAS MARKED AS "RECONSIDERATION" WITH LAWS THAT SHOW THE DENIAL IS UNLAWFUL."

**Amount in Dispute:** \$514.52

### Respondent's Position

"The equipment for which Peak seeks payment is not recommended by the ODG as a first-line

treatment modality and Peak has not documented the prerequisites for consideration as a second-line option on a trial basis. Accordingly, Peak was required to obtain preauthorization under Rule 134.600(p)(12). Since it did not do so, it is not entitled to payment.”

**Response submitted by:** Stone Loughlin & Swanson LLP

## **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 §133.240](#) sets out the guidelines for adverse determinations.
3. [28 TAC §19](#) sets out the requirements of adverse determination notification.
4. [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.

- 197 – Precertification/authorization/notification/pre-treatment absent.

### Issues

1. Is the insurance carrier’s position statement supported?
2. What rule is applicable to payment of durable medical equipment.

### Findings

1. The requestor is seeking reimbursement of durable medical equipment for date of service May 30, 2023. The insurance carrier denied the disputed service for lack of prior authorization and states in their position statement, “The equipment for which Peak seeks payment is not recommended by the *ODG* as a first-line treatment modality and Peak has not documented the prerequisites for consideration as a second-line option on a trial basis. Accordingly, Peak was required to obtain preauthorization under Rule 134.600 (p)12).”

DWC Rule 28 Texas Administrative Code §133.240 (q) states, in relevant part, “When denying payment due to an adverse determination under this section, the insurance carrier shall

comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...”

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003 (b)(31) or §133.240 (q). Therefore, the insurance carrier did not appropriately raise their position that ODG guidelines are not met thus prior authorization was required. This denial reason will not be considered in this review

2. 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...”

The applicable Medicare payment policy for durable medical equipment at [www.cms.gov](http://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.

Review of the submitted medical bill found the place of service indicated was “11” (physician’s office or clinic) in box 24D.

The submitted medical bill does not indicate the disputed services were for use in the home but rather the physician’s office.

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**

February 6, 2024

Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

## 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).