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
Richardson ISD

MFDR Tracking Number
M4-24-0997-01

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 25, 2023	E0730	$167.38	$0.00
May 25, 2023	E0731	$162.93	$0.00
May 25, 2023	L0627	$473.93	$0.00
May 25, 2023	E0215	$94.21	$0.00
May 25, 2023	E1399	$35.00	$0.00
	Total	$933.45	$0.00

Requestor's Position

"THE CLAIM ATTACHED WAS INITIALLY DENIED DUE TO PRE-AUTH NOT APPROVED OR REQUESTED. A RECONSIDERATION WAS SENT WITH PROOF THAT PRE-AUTH IS NOT REQUIRED PR TX ADMIN CODE 134.600. THE CARRIER SENT A SECOND DENIAL STATING NO PRE-AUTH APPROVED OR REQUESTED. WE HAVE ATTACHED PROOF THAT THE FIRST RECONSIDERATION WAS MARED AS "RECONSIDERATION" WITH AN APPEAL LETTER STATING ADMIN CODE 134.600."

Amount in Dispute: $933.45

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 25, 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 ODG guidelines not met thus equipment required prior authorization 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, 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" in box 24D or that the healthcare was provided in an office or clinic.

   The submitted medical bill indicates the disputed services were provided in the physician's office, not the injured workers' home. 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	February 6, 2024 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.