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
Indemnity Insurance Company

MFDR Tracking Number
M4-24-0017-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
September 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 5, 2023	L1831 x 2	$439.31	$439.31
May 5, 2023	A9901	$50.00	$0.00
	Total	$489.31	$439.31

Requestor's Position

"Once of the items was replaced due to incorrect measurement. The treating doctor requested, BILATERAL knee braces. Once the patient was accurately measured by our office, PEAK INTEGRATED HEALTHCARE, we provided her with 1 new brace and 1 replacement brace due to the first one not fitting."

Amount in Dispute: $489.31

Respondent's Position

"Downs & Stanford, P.C. has been retained to represent the interests of Indemnity Insurance Company of North America... Enclosed please find the EOBs for the date of service in dispute."

Submitted by: Downs & Stanford, P.C.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 5264 - Payment is denied-service not authorized.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's denial supported?
2. What services are in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of DME rendered on May 5, 2023, and billed under HCPCS codes L1831-RA-RT, L1831-LT, and A9901. The requestor is seeking reimbursement in the amount of $489.31. The insurance carrier denied the disputed services with reduction codes 5264 and 197 due to lack of preauthorization. Using the previously mentioned denial reduction codes, the insurance carrier audited and rejected the disputed service. A review of the submitted documentation finds the following.

   28 TAC 134.600 (P)(9) states in pertinent part, "(p) non-emergency health care requiring preauthorization includes… (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   A review of the submitted documentation does not document that the disputed services were more than $500 billed charge per item, nor does it document a purchase or expected cumulative rental.

The DWC finds that the insurance carrier's denial due to lack of preauthorization is not supported, as a result, the disputed services are reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement for HCPCS codes L1831 x 2 and A9901 rendered on May 5, 2023. Because the insurance carrier's denial for lack of preauthorization is not supported, the following rules apply.

   28 TAC §134.203(b)(1) states "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."

   HCPCS Code L1831 is described as, "Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment."

   The requestor billed one unit of L1831 with modifier "RT" described as "Right" and modifier "RA" described as "Replacement of a DME, Orthotic or Prosthetic item due to loss, stolen, or irreparable damage."

   The requestor billed a second unit of L1831 with modifier "LT" described as "Left".

   HCPCS Code A9901 is described as, "DME delivery, set up, and/or dispensing service component of another HCPCS code."

   The disputed services are reviewed pursuant to the applicable rules and guidelines.

3. 28 TAC §133.307(c)(2)(o) states, Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.

   Durable medical equipment is subject to 28 TAC §134.203(d)(3) 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; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

For HCPCS code A9901 the following has been decided. The applicable DMEPOS fee schedule finds no fee schedule amount for HCPCS code A9901. Review of the Texas Medicaid fee schedule finds no fee schedule amount for A9901. The service in dispute will be reviewed pursuant to 28 TAC §134.203(f) which states, For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)"

The division concluded above that §134.1 applies and states, Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

For that reason, 28 TAC §133.307(c)(2)(O) also applies and, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation for HCPCS code A9901 finds:

- The requestor does not discuss or demonstrate how reimbursement of $50.00 for code A9901 is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support the claim that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. For the reasons stated above, the division concludes that the requestor failed to support its request for reimbursement for HCPCS code A9901. For that reason, no reimbursement is recommended.

For HCPCS code L1831-RA and L1831, the following has been decided. A review of the submitted documentation finds that the requestor documented and billed for a bilateral knee brace rendered on May 5, 2023. As a result, reimbursement is recommended.

The DMEPOS fee schedule amount for L1831 supplied in Texas is $339.31 x 125% = MAR of $424.13 x 2 units = $848.26. The requestor seeks $439.31, as a result, this amount is recommended.

The DWC finds that the requestor submitted sufficient documentation to support the reimbursement of HCPCS code L1831 x 2, therefore reimbursement is recommended in the amount of $439.31. The requestor did not submit sufficient documentation to support the reimbursement of HCPCS code A9901, as result, reimbursement cannot be 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.

The DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $439.31 reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $439.31 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 13, 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.