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
Hartford Fire Insurance Company

MFDR Tracking Number
M4-24-0115-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
September 13, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 4, 2023	A9300	$255.00	$0.00
May 4, 2023	E1399	$40.00	$0.00
	Total	$295.00	$0.00

Requestor's Position

"This patient is working on physical therapy in our office, so he/she does not have any vital tubes or catheters which allows for exercise equipment to be furnished for at home treatment to help with pain and mobility. ALSO ATTACHED ODG GUIDELINES RECOMMENDING STRETCHING EQUIPMENT."

Amount in Dispute: $295.00

Respondent's Position

"The original bill was processed and denied on 5/26/23 under control number... as maximum medical Improvement has been reached. See attached MMI report Per adjuster: Will not pay any bills that come in after the pay thru date of 09/14/22. Claimant went for more treatment on 10/05/22 after starting a new job. Possible new injury."

Submitted by: The Hartford

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.
5. 28 TAC §134.1 sets out the medical reimbursement policies.

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 exceeds the fee schedule allowance.
- 309 - The charge for this procedure exceeds the fee schedule allowance.
- MMI – The opinion of the designated doctor is given presumptive weight regarding MMI and impairment. Maximum medical improvement has been reached.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 96 – Non covered charges.
- NABA – Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review.

Issues

1. Are the insurance carrier's denial reasons 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 4, 2023, and billed under HCPCS codes A9300 and E1399. The requestor is seeking reimbursement in the amount of $295.00. The insurance carrier denied the disputed services with reduction codes 7 and 97 due to benefit or supply is included in the value of another procedure performed on the same day. 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.

A review of the medical bills finds that the requestor billed HCPCS codes A9300 and E1399 on May 4, 2023.

28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care. A review of 28 TAC §134.600 does not require preauthorization for the disputed DME. The DWC therefore 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 A9300 and E1399 rendered on May 4, 2023, the following rules apply to the review of the disputed DME charges.

   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 A9300 is described as, "Exercise equipment."
   - HCPCS Code E1399 is described as, "Durable medical equipment, miscellaneous."

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

3. 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.

   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.

28 TAC §134.1 applies to the disputed DME and requires, "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 HCPCS code A9300 and E1399 the following has been decided. A review of the DMEPOS fee schedule finds no assigned fee schedule amount for HCPCS codes A9300 and E1399. A review of the Texas Medicaid fee schedule finds no assigned fee schedule amount for HCPCS codes A9300 and E1399. The service in dispute will be reviewed pursuant to 28 TAC §134.1 of this title (relating to Medical Reimbursement).

The division concluded above that 28 TAC §134.1 applies to fair and reasonable reimbursement. 28 TAC §134.1 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 codes A9300 and E1399 finds:

- The requester does not discuss or demonstrate how reimbursement of the amount sought for HCPCS code A9300 and E1399 is a fair and reasonable reimbursement.
- The requestor submitted insufficient 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 submitted copies of various EOBS in support of the fair and reasonable reimbursement, however the billed DME codes are miscellaneous codes and therefore the DWC is unable to decern whether the HCPCS code billed for those charges are for the same or similar services in dispute.

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 DWC concludes that the requestor failed to support its request for reimbursement for HCPCS codes A9300 and E1399. Therefore, reimbursement is not 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 not 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 14, 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.