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**
Comprehensive Hearing Center of Texas

**Respondent Name**
Mitsui Sumitomo Insurance Co of America

**MFDR Tracking Number**
M4-24-0909-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 28, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| May 3, 2023 | V5261 | $1,478.13 | $0.00 |
| May 3, 2023 | V5267 | $236.57 | $0.00 |
| May 3, 2023 | V5267 | $236.57 | $0.00 |
| May 3, 2023 | V5267 | $151.00 | $0.00 |
| May 3, 2023 | V5268 | $151.00 | $0.00 |
| May 3, 2023 | V5270 | $200.00 | $0.00 |
| May 3, 2023 | V5264 | $26.95 | $0.00 |
| | **Total** | $2,480.23 | $0.00 |

## Requestor's Position

"Please process and pay our claim based on the usual and customary payments we are normally paid for these services."

**Amount in Dispute:** $2,480.23

## Respondent's Position

"The provider is not entitled to any additional payment."

**Response submitted by:** Flahive, Ogden & Latson

# 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 fee guidelines for Level II HCPCS codes.
3. 28 TAC §134.1 sets forth general provisions related to medical reimbursement.
4. The Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Denial Reasons

- 150 – Payment adjusted/unsupported service level.
- 510 – Payment Determined.
- B13 – Payment for service may have been previously paid.
- P12 – Workers' Compensation State Fee Schedule Adj.
- W3 – Appeal/Reconsideration.
- 226 – Info requested was not provided or was insuff.
- 97A – Provider appeal.
- ORC – See Additional Information.
- Note: Appeal of #39298309. Obtaining preauthorization is a medical necessity determination, it is not a guarantee of payment.
- Note: Obtaining preauthorization is a medical necessity determination. It is not a guarantee of payment. None of the documentation submitted by the hcp provides specific details of the items provided. What is the brand of the items dispensed?
- P5 – Based on payor reasonable/customary fees.
- Note: Manufacturer's invoice required for reimbursement as per TX Medicaid which was not included in the billing. Additionally, this item is by report. Full description required.

Issues

1. Is the carrier's reduction / denial supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor's position supported?

Findings

1. The requestor seeks reimbursement for hearing aids for the date of service May 3, 2023. The insurance carrier issued payments in the following amounts.
    - V5261 – Billed amount $6,400.00, Carrier paid $4,500.00
    - V5267 – Billed amount $250.00, Carrier paid $0.00 (Misc code description – wax guard, filters, domes)
    - V5267 – Billed amount $350.00, Carrier paid $199.00 (Misc code description – MRIC charge for work / avg retail price)
    - V5267 – Billed amount $350.00, Carrier paid $199.00 (Misc code description – MRIC charge for home /avg retail price)
    - V5268 – Billed amount $250.00, Carrier paid $170.00.
    - V5270 – Billed amount $350.00, Carrier paid $150.00.
    - V5264 – Billed amount $300.00, Carrier paid $96.36.

    The total amount in dispute listed on the DWC60 is $2,480.23. Disputed Code V5267 – "Hearing aid or assistive listening device/supplies/accessories, not otherwise classified," with a billed amount of $250 was denied with reason code "226" information was insufficient. Additionally, a note from the insurance carrier requested a manufacturer's invoice to support the type and number of services billed under this miscellaneous code.

    Review of the requestor's submitted documentation found the following statement, "Widex wax guards, filters & domes 3 yr. supply…". This statement does not provide adequate information to allow adjudication. This denial is upheld.

    For the remaining codes under dispute, the carrier reduced the requested amount in accordance with payor reasonable/customary fees.

2. DWC Rule 28 TAC §134.203 (d)(2)(3) states, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (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;

    The codes in dispute are "V" codes. These codes are not subject to the rule shown above.

    The DWC finds that the services in dispute are not assigned a relative value unit or payment by Medicare and therefore, are subject to 28 TAC §§134.203(f) and 134.1.

    28 TAC §134.203(f) 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(f) 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.)"

DWC Rule 28 TAC §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "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."

The Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

3. In support of reasonable and customary the requestor states the following, "All I have to do is prove what the industry payments normally are. I have attached a spreadsheet of all payments we have received for the same CPT codes that we submitted for (injured worker's name.) I have attached a page for each code for you to see what our payments have been from other worker's compensation insurance carriers as well as multiple eobs showing the actual payments."

   Rule §133.307(c)(2)(N) requires the requestor to provide a position statement of the disputed issues, including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue.

   Rule §133.307(c)(2)(O) further requires that when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or rate, the requestor shall provide: documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Rule §134.1

   While the redacted explanation of benefits (eobs) do show how similar procedures provided in similar circumstances were reimbursed, this is only one of the criteria noted in the rule above.

   The requestor did not submit documentation to support the requested amount of $2,480.23 meets all the criteria of 28 TAC §134.1 shown above. No additional reimbursement 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 additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | November 20, 2024 |
| Signature | Medical Fee Dispute Resolution Officer | 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. 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.