TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Comprehensive Hearing Center of Texas

Respondent Name
City of Austin

MFDR Tracking Number
M4-24-1030-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 12, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 18, 2023	V5261	$0.00	$0.00
October 18, 2023	V5267	$350.00	$0.00
October 18, 2023	V5267	$450.00	$0.00
October 18, 2023	V5267	$450.00	$0.00
October 18, 2023	V5268	$249.90	$0.00
October 18, 2023	V5270	$350.10	$0.00
October 18, 2023	V5264	$101.90	$0.00
October 18, 2023	V5160	$300.00	$0.00
	Total	$2,251.90	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "According to the EOB remark code 97; the following codes have been included in the payment of V5261: V5267 X 3, V5268, V5270, V5264 and V5160. This is incorrect; these items are separately payable according to the Workers Compensation Fee Schedule and we are under no contract that specifies differently."

Supplemental response dated March 5, 2024.

"We would like to continue with the dispute; there are several CPT codes that still remain unpaid."

Amount in Dispute: $2,251.90

Respondent's Position

"After the carrier received the DWC-60 packet, it reprocessed the provider's bill and has recommended an additional payment of $701.90 plus interest. Once we received the new EOR, we will supplement this response."

Supplemental response submitted February 5, 2024.

"Carrier has previously responded to this dispute on February 1, 2024. As noted in the carrier's initial response, it was reprocessing the provider's medical bill and had concluded that the provider was entitled to an additional $701.90. We are attaching a copy of the EOR recommended that amount. The EOR is dated January 31, 2024."

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 reimbursement 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

- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
- 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.
- 2008 – Additional payment made on appeal/reconsideration.
- 237 – The recommended allowance is based on usual, customary and reasonable rates for this geographical area.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5088 – Service reviewed per claims examiner instructions.

- 877 – Reimbursement is based on the contracted amount.
- 97 – Recommended allowance made for two/co surgeon. Internal use only.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- W3 – Bill is a reconsideration or appeal.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
- MA46 – Alert: The new information was considered but additional payment will not be issued.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. Are the services subject to contract?
2. Is the insurance carriers' denial supported?
3. What rule is applicable to reimbursement?

Findings

1. The insurance carrier made an additional payment upon receipt of MFDR on February 2, 2024. This explanation of benefits included a reduction based on "contracted amount." Review of the submitted documentation and information known to the Division found insufficient information to support a contract that exists between the two parties. This reduction will not be considered in this review.

2. The insurance carrier made an additional payment for codes V5260, V5270 and V5264. These codes are no longer in dispute. The requestor seeks payment of the following HCPCS codes.
    - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified. Billed amount $350.00, Carrier paid $0.00
    - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified. Billed amount $450.00, Carrier paid $0.00
    - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified. Billed amount $450.00, Carrier paid $0.00
    - V5160 – Dispensing fee, binaural. Billed amount $300.00. Carrier paid $0.00.

    Codes V5267 and V5160 was denied as 97 – "Recommended allowance made for two/co surgeon." The services in dispute are for hearing aid accessories not surgeon services. This denial is not supported. The insurance carrier's explanation of bill review processed on October 30, 2023, indicates 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Insufficient evidence was found to support the insurance carrier's denial of code V5267 and V5160 as being included in benefit allowance of another service. The services in dispute will be reviewed per applicable fee guidelines.

3. The requestor states in their reconsideration, "…these items are separately payable according to the Workers Compensation Fee Schedule…"

    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. Because these codes are not subject to the Workers' Compensation Fee Schedule.

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

    DWC Rule 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(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)."

    DWC Rule 28 TAC §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, 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.

DWC Rule 28 TAC§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.

DWC Rule TAC §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 requester 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) does 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 $2,251.90, which 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 22, 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 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.