



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Comprehensive Hearing Center

Respondent Name

City of Austin

MFDR Tracking Number

M4-24-1126-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2023	V5261	\$0.00	\$0.00
December 5, 2023	V5267	\$350.00	\$0.00
December 5, 2023	V5267	\$450.00	\$0.00
December 5, 2023	V5267	\$499.00	\$0.00
December 5, 2023	V5268	\$249.90	\$0.00
December 5, 2023	V5270	\$350.10	\$0.00
December 5, 2023	V5264	\$101.90	\$0.00
December 5, 2023	V5160	\$300.00	\$0.00
December 5, 2023	V5260	\$2,000.00	\$0.00
Total		\$4,300.90	\$0.00

Requestor's Position

"We are requesting immediate reconsideration for this claim. 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 submitted March 14, 2024

"Although an additional payment was received, CPT V5267 X 3 and V5160 remain unpaid. We will continue with the dispute."

Amount in Dispute: \$4,300.90

Respondent's Position

"The provider filed a DWC 60, seeking Medical Fee Dispute Resolution for a date of service of December 5, 2023. The provider billed a total of \$11,699. The provider's initial CMS 1500 is two pages. The provider did not identify the total amount of the charges on the CMS 1500s other than to identify the total amount for each individual page. We are attaching a copy of the provider's CMS 1500s and the carrier's EORs. As the provider noted, prior to the filing of the DWC 60, the carrier had paid the provider \$5,800. The provider is seeking additional payment of \$4,300.90. Following the filing of the DWC 60, the carrier issued an additional payment of \$2,701.90 plus interest of \$3.75. The additional payment of the principal amount of \$2,701.90 means that the carrier has now paid the provider \$8,501.90 before the payment of interest. 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 \(TLC\) §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 134.1](#) sets out the general rules for medical reimbursement.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 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.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 5088 – Service reviewed for claims examiner instructions.
- N702 – Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- Note: 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.

Issues

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

Findings

1. The requestor supplemented their response to MFDR to indicate the following codes remain in dispute after insurance carrier made an additional payment.
 - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified, \$350.00.
 - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified, \$450.00.
 - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified, \$499.00
 - V5160 – Dispensing fee, binaural, \$300.00

2. The insurance carrier denied the charges as 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Review of the submitted documentation found insufficient evidence to support the services in dispute are packaged into another service/procedure. 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.

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 28 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 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) 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 reimbursement

for the remaining disputed codes, V5267 x 3, and V5160. Because the requestor did not meet all the required criteria in 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.

The DWC finds the requestor 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

_____	_____	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, 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 prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.