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

Respondent Name
City of Austin

MFDR Tracking Number
M4-24-1224-01

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
November 29, 2023	V5261	$0.00	$0.00
November 29, 2023	V5267	$350.00	$0.00
November 29, 2023	V5267	$450.00	$0.00
November 29, 2023	V5267	$450.00	$0.00
November 29, 2023	V5268	$249.90	$0.00
November 29, 2023	V5270	$350.10	$0.00
November 29, 2023	V5264	$101.90	$0.00
November 29, 2023	V5160	$300.00	$0.00
	Total	$2,251.90	$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."

Amount in Dispute: $2,251.90

Respondent's Position

The Austin carrier representative for City of Austin is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on February 6, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

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, 5088, 309, P12, 97, and B20, but no explanation of these codes was found on submitted "Bill Detail"

The carrier reviewed the reconsideration request and on January 4, 2024, they denied the claim with the following.

- 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.

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 seeks reimbursement for services billed for date of service November 29, 2023, under the following HCPCS codes.
   - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.
   - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.
   - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.
   - V5268 – Assistive listening device, telephone amplifier, any type.
   - V5270 – Assistive listening device, television amplifier, any type.
   - V5264 – Ear mold/insert, not disposable, any type.
   - V5160 – Dispensing fee, binaural.
2. The requestor states in their position statement, "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."

   Review of the submitted original explanation of benefits was not included by either party, but the respondent indicates the services were denied due to being included into V5261. Insufficient evidence was found to support the insurance carrier's denial. The services in dispute will be reviewed per applicable fee guidelines.

3. 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 that the requested amount of $2,251.90 met 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.

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

Signature	Medical Fee Dispute Resolution Officer	November 22, 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, 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.