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
M4-24-1467-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 13, 2024	V5261	$2,900.00	$0.00
February 13, 2024	V5260	$0.00	$0.00
February 13, 2024	V5267	$350.00	$0.00
February 13, 2024	V5267	$450.00	$0.00
February 13, 2024	V5267	$499.00	$0.00
February 13, 2024	V5268	$450.00	$0.00
February 13, 2024	V5270	$350.00	$0.00
February 13, 2024	V5264	$101.90	$0.00
February 13, 2024	V5160	$300.00	$0.00
	Total	$5,400.90	$ $0.00

Requestor's Position

"The Reason Codes are also inaccurate. Reason Code N702: Decision based on review of previously adjudicated claims or for claims in process for the same/similar types of service; our office has documentation of previous claims that prove this is inaccurate. Reason Code N600: Adjusted based on the applicable fee schedule for the region in which the service was rendered; this claim was not adjudicated IAW the Workers Compensation Fee Schedule. These CPT Codes should be paid IAW the Workers Compensation Fee Schedule."

Supplemental response submitted April 24, 2024

"Please continue with Fee Dispute. Additional payment was received; but some items remain unpaid."

Amount in Dispute: $5,400.90

Respondent's Position

"The provider filed a DWC 60, seeking medical fee dispute resolution for date of service of February 13, 2024. The provider submitted a medical bill the total $11,699. The provider acknowledges that the carrier had already paid it the amount of $4,900. The provider is seeking additional reimbursement of $5,400.90… It is the carrier's position that once that amount is paid, the provider is not entitled to any additional reimbursement. Once we receive the additional EOR, we will forward a copy to the medical review division and to the provider."

Respondent's Supplemental Position

Carrier has previously responded to this dispute on March 27, 2024. As noted in the carrier's initial response dated March 27, 2024, the carrier was processing an additional payment in the amount of $3,601.80. We are attaching a copy of the EOB reports that amount. The provider is in agreement with the carrier's current payment, and we would ask the provider withdraw its request for medical fee dispute resolution."

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.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 948 – Re-reviewed at providers request with additional information and documentation addition payment suggested.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 - Bill is a reconsideration or appeal.
- M46 – Alert: The new information was considered but additional payment will not be issued.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 247 – A payment or denial has already been recommended for this service.
- 18 – Exact duplicate claim/service.
- N702 – Decision based on review of previously adjudicated claim or for claims in process for the same/similar type of service.

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.
    - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise specified.
    - V5267 – Hearing aid or assistive listening device/supplies/accessories, not otherwise

specified.

- V5160 – Dispensing fee, binaural.

2. The insurance carrier denied the charges as benefit 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 procedure. The services in dispute will be reviewed per applicable fee guideline.
3. The requestor states in their reconsideration , "……these CPT codes are not included in any other service/procedure that has already been adjudicated. …These codes should also be paid IAW 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 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

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.