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
Peak Integrated Healthcare

Respondent Name
Great American Alliance Insurance Company

MFDR Tracking Number
M4-24-2139-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
June 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 16, 2023	E0730	$167.38	$167.38
November 16, 2023	E0731	$162.93	$162.93
November 16, 2023	E0215	$94.21	$94.21
November 16, 2023	E0190	$55.00	$0.00
November 16, 2023	E1399	$20.00	$0.00
November 16, 2023	L3809	$262.38	$262.38
	Total	$761.90	$686.90

Requestor's Position

"The claim attached was initially denied due to pre-auth not approved or requested. A reconsideration was sent with proof that pre-auth is not required for single DME items under $500.00. The carrier sent a second denial stating 'continue to deny codes'. We have attached copies for the first 2 appeals."

Amount in Dispute: $761.90

Respondent's Position

"The provider filed a DWC 60, seeking medical fee dispute resolution for date of service of November 16, 2023. The provider billed for durable medical equipment (DME). The bill for the DME totaled $761.90. The carrier has denied the provider's request for payment. We are attaching a copy of the provider's CMS 1500, the information concerning the DME, the carrier's initial EOB, the provider's request for reconsideration and the carrier's subsequent EOBs. Those EOBs are dated January 3, 2024, March 7, 2024 and May 9, 2024. The provider's position is that he can bill as much as he wants and preauthorization is not required so long as each individual piece of equipment does not exceed $500. …The carrier disagrees with the provider's position, if the DME is outside of the ODG or is not contained within the ODG, preauthorization is required under Rule 137.100. The provider's position is based upon its interpretation of Rule 134.600 but that position fails to address Rule 137.100. The failure to obtain preauthorization when preauthorization is required, means that the provider is not entitled to reimbursement."

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 fair and reasonable reimbursement guidelines.

Denial Reasons

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

- 16 – Claim service lacks information or has submission/billing error(s).
- 270 – No allowance has been recommended for this procedure/service/supply. Please see special *note* below.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- W3 – In accordance with the TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- 270 – Continue to deny with the provided codes. Prior auth required.

Issues

1. Did the respondent raise a new issue?
2. Was prior authorization required?
3. What rule is applicable to reimbursement?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of durable medical equipment rendered on November 16, 2023. The insurance carrier states in their position statement, "The carrier disagrees with the provider's position, if the DME is outside of the ODG or is not contained within the ODG, preauthorization is required under Rule 137.100."

   A review of the submitted information finds insufficient documentation to support that an EOB was presented to the health care provider, giving notice of the ODG exceeded raised in the insurance carrier's response to MFDR.

   DWC Rule 28 TAC §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

2. The insurance carrier's explanation of benefits denied the services as "Prior auth required." DWC Rule 28 TAC §134.600 (p)(9) states, "Non-emergency health care requiring preauthorization includes, …all durable medical equipment (DME) **in excess of $500 billed charges per item**."
   Review of the submitted medical bill found none of the items billed exceeded $500 in billed charges. The insurance carrier's denial is not supported. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines.

3. DWC Rule 28 TAC §134.203 (d)(1) states in pertinent parts, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes shall be determined as follows: 125 percent of the fee listed for the code in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   Review of the applicable DMEPOS fee schedule found the following fee schedule amounts.

   - E0730 – NU, $167.38 x 125% = $209.22. Requestor is seeking $167.38.
   - E0731 – NU, $162.93 x 125% = $203.66. Requestor is seeking $162.93.
   - E0215 – NU, $94.21 x 125% = $117.76. Requestor is seeking $94.21.
   - E0190 – NU – Not priced. DWC Rule §134.1 (e)(f) states in pertinent parts, "Medical reimbursement for health care not provider through a workers' compensation health care network shall be, in the absence of an applicable fee guideline or negotiated contract, a fair and reasonable reimbursement amount. Fair and reasonable reimbursement shall be consistent with the criteria of Labor Code §413.011; ensure that

similar procedures provided in similar circumstances receive similar reimbursement; and 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.

DWC Rule 134.203 (g) states in pertinent parts, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid, or the Division, reimbursements shall be provided in accordance with 134.1 of this title."

Review of the submitted documentation found insufficient evidence to support the amount being requested by the health care provider met the requirements of fair and reasonable. No payment recommended.

- E1399 – NU - Not priced. As above.
- L3809 – NU, $262.38 x 125% = $327.97. Requestor is seeking $262.38.

4. The total maximum allowable reimbursement is $858.61. The requestor is seeking $686.90 for the disputed services. This amount 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 established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Great American Alliance Insurance Co must remit to Peak Integrated Healthcare $686.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 10, 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.