



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Peak Integrated  
Healthcare

**Respondent Name**

American Home Assurance Co

**MFDR Tracking Number**

M4-24-2349-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

June 25, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 5, 2024	K0878	\$3500.00	\$0.00
February 5, 2024	A9901	\$175.00	\$0.00
<b>Total</b>		<b>\$3675.00</b>	<b>\$0.00</b>

### Requestor's Position

"The first denial was denied due to extent. We sent in a corrected claim well within the appeal guidelines for workers compensation. The second denial from Gallagher Bassett stated 'duplicate.' We sent proof that we clearly marked the appeal as 'RECONSIDERATION/APPEAL' on the letter and it was also marked in red on the claim form. Gallagher Bassett denied the claim for the third time on 6/11/2024 for reasons 'duplicate.'"

**Amount in Dispute:** \$3,675.00

### Respondent's Position

The Austin carrier representative for American Home Assurance Co., is Flahive, Ogden & Latson is. The representative was notified of this medical fee dispute on July 2, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within

14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

**Response submitted by:** N/A

## **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 coding and billing guidelines for durable medical equipment.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 219 – Based on extent of injury
- Adj – (redacted) is not accepted
- ZX10 – Resolution Manager denial
- 18-6/TX224 – Exact duplicate claim/service

### Issues

1. Did the respondent support the extent of injury denial?
2. Does the submitted code match the description of prior approved durable medical equipment?

### **Findings**

1. The requestor is seeking reimbursement of durable medical equipment rendered in February of 2024. The insurance carrier denied the services due to the extent of injury.

DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices “shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim.”

Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. The requestor seeks reimbursement of the following HCPCS codes.
  - K0878 – Power wheelchair, group 4 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds.
  - A9901 – DME delivery, set up, and/or dispensing service component of another HCPCS code.

DWC Rule 28 TAC §134.203 (b) states in pertinent part, “For coding, billing, reporting and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing and correct coding initiatives (CCI) edits...”

Review of the applicable DWC rules applicable to DME, Rule §134.600 (p)(9) states in pertinent part, “Non-emergency health care requiring preauthorization includes: all durable medical equipment (DME) in excess of \$500 bill charges per item.”

Review of the submitted documents found a recommendation for preauthorization for DME “Lightweight foldable power wheelchair.” The description of the approved item does not match the description of the HCPCS Code K0878 that was submitted on the medical bill and referenced on the same prior authorization. The specifications of code K0878 is found at, [www.cms.gov](http://www.cms.gov), Power Mobility Devices - Policy Article A52498 and states, “All Group 4 PWCs (K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886) must have the specified components and meet the following requirements:

- Standard integrated or remote proportional joystick
- Non-expandable controller
- Capable of upgrade to expandable controller
- Capable of upgrade to alternative control devices
- May not have crossbrace construction
- Accommodates seating and positioning items (e.g., seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports) (except captains chairs)

Drive wheel suspension to reduce vibration  
Length - less than or equal to 48 inches  
Width - less than or equal to 34 inches  
Minimum Top End Speed - 6 MPH  
Minimum Range - 16 miles  
Minimum Obstacle Climb - 75 mm  
Dynamic Stability Incline - 9 degrees"

The specifications shown above do not allow for a crossbrace construction which would allow the wheelchair to be foldable.

The DWC finds the requirements of correct coding outlined in DWC Rule 28 TAC §134.203 (b) are not met. No reimbursement is recommended.

Regarding code A9901, this code is classified as "X" statutorily excluded from coverage. As, the Medicare payment policy does not allow payment, no reimbursement is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**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

October 11, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).