**Texas Department of Insurance, Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor's Name and Address:<br><br>Medi Smart Systems<br>P.O. Box 330279<br>Houston, TX 77233-0279 | MFDR Tracking #: M4-06-4283-01<br>DW<br>Injured<br>Da |
| Respondent Name and Box #:<br><br>Trinity Universal Insurance Co. of Kansas<br>Rep. Box #: 19 | Emplo<br>Insurance |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMEI

Requestor's Position Summary as stated on the Table of Disputed Services: "Unbundled charge. No paid accordingly to $75.00 per day. Information supports the need of the supplies that are needed to operate the unit (cold therapy). Authorization number is listed. Proper code given for the service given (lumbar)."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $1,608.86
3. CMS 1500s
4. EOBs

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: A position summary was not submitted with the response.

Principle Documentation:

1. Response to DWC 60

## PART IV: SUMMARY OF FINDINGS

| Eligible Dates of Service (DOS) | CPT Codes and Calculations | Denial Reasons | Part V Reference | Amount Ordered |
|---|---|---|---|---|
| 09/14/05 | CPT Code 99002 | 97 (855-013), W4 (920-002) | 1, 2 | $0.00 |
| 09/14/05 – 09/24/05 | HCPCS Code E0236 ($44.25 x 125% = $55.32 x 14 = $774.48 – 774.34 (carrier payment) = $0.14) | W1 (663), W4 (920-002) | 1, 3, 5 | $0.00 |
| 09/14/05 | HCPCS Code E0249 ($74.70 x 125% = $93.38 - $124.50 (carrier payment) = $31.12 overpayment) | W1 (663) | 1, 4, 5 | $0.00 |
| 09/14/05 | HCPCS Code L0515 | 15 (855-024) | 1, 6 | $0.00 |
| **Total:** | | | | $0.00 |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

[redacted]

1. These services were denied by the Respondent with reason code "97 (855-013) – Payment denied – The service is included in the global value of another billed procedure"; "W4 (920-002) – Service is denied for lack of proof of pre-authorization"; "W1 (663) – Reimbursement has been calculated according to state fee schedule guidelines"; "W4 (920-002) – No additional reimbursement allowed after review of appeal/reconsideration"; and "15 (855-024) – Payment adjusted because the submitted authorization number is missing, invalid , or does not apply to the billed services or provider and service is denied for lack of proof of pre-authorization ."
2. CPT Code 99002 for date of service 09/14/05 denied as "97 (855-013) – Payment denied – The service is included in the global value of another billed procedure." According to 28 Texas Administrative Code (TAC) Section 134.202(b) this code is considered a bundled code and not separately reimbursable Therefore, reimbursement is not recommended.
3. HCPCS Code E0236 for dates of service 09/14/05 through 09/24/05 (14 dates of service). The Requestor billed $1,050.00 for the dates of service in dispute. The Respondent reimbursed the Requestor $774.84. Per 28 TAC Section 134.202(c)(2)(A) this code is valued at $55.32 (44.25 x 125%) per day; therefore the Respondent did not pay correctly.
4. HCPCS Code E0249 for date of service 09/14/05. The Requestor billed $223.00 and the Respondent reimbursed this DME item at $124.50. According to 28 TAC Section 134.202(c)(2)(A) this code is valued at $93.38 ($74.70 x 125%); therefore the Requestor was overpaid in the amount of $31.12.
5. Because the Requestor was overpaid for HCPCS Code E0249, the reimbursement amount on HCPCS Code E0236 ($0.14) is not due to the Requestor.
6. HCPCS Code L0515 for date of service 09/14/05. Per 28 TAC Section 134.202(c)(2) this HCPCS code was deleted on January 1, 2005; therefore, reimbursement cannot be recommended.

## PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section. 413.011(a-d);
- Texas Labor Code Section. 413.031;
- Texas Labor Code Section. 413.0311;
- 28 Texas Administrative Code Section. 134.1;
- 28 Texas Administrative Code, Section. 134.202; and
- Texas Government Code, Chapter 2001, Subchapter G

## PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

**ORDER:**

| | | |
|---|---|---|
| [redacted] | [redacted] | July 30, 2008 |
| Authorized Signature | Auditor III<br>Medical Fee Dispute Resolution | Date |

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

[redacted]

[redacted]