Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NATIONAL MEDICAL EQUIPMENT AND SUPPLIES
PO BOX 940008
HOUSTON TX 77094

Respondent Name

CITY OF EL PASO

MFDR Tracking Number
M4-11-2379-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 1, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "134.600(8)."

Amount in Dispute: $1,340.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 12/11/2009 Dr. Marioni wrote a Prescription and Letter of Support to National Medical Equipment & Supplies for EMS/Tens Unit, Conductive Garment and Traction Unit. On 12/17/2009 we received the bill from National Medical Equip & Supplies. On 01/15/10 the charges were reviewed and based on ODG protocol, the charges were denied as 'Precertification/authorization/notification absent'. On 07/30/2010 an incomplete reconsideration was submitted. This was returned to the provider on 08/02/2010 as 'Incomplete' and advised documentation to submit for review. No response to our request was submitted by the provider. Therefore, we maintain our denial for preauthorization."

Response Submitted by: CAS Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 11, 2009	E0745, E0731 and E0855	$1,340.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 167 – This these diagnosis(es) is (are) not covered
   - 197 – Precertification/authorization/notification absent

Issues

1. Did the insurance carrier maintain the denial of 167?
2. Did the requestor obtain preauthorization for the DME charges as required by 28 Texas Administrative Code §134.600 (p)(12)?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the EOB submitted by the requestor indicates that the insurance carrier denied HCPC codes E0745, E0731 and E0855 with denial reason code "167 – This these diagnosis(es) is (are) not covered." Review of the insurance carrier's position statement does not maintain the denial of 167, as a result, the disputed charges will be reviewed pursuant to 28 Texas Administrative Code §134.600.
2. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   Per 28 Texas Administrative Code §134.600 (p)(12) "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)..."

   The requestor appended modifier –NU to each disputed services indicated above. The –NU modifier is defined as NU – NEW DURABLE MEDICAL EQUIPMENT PURCHASE. This modifier is used for new DME items that are purchased. When using the NU modifier, you are indicating you have furnished the injured employee with a new (never used) piece of equipment.

   Review of the submitted documentation does not support that the requestor obtained preauthorization for DME codes E0745-NU, E0731-NU and E0855-NU; total billed $1,340.00; rendered on December 11, 2009.
3. Review of the submitted documentation finds that the requestor has not submitted documentation to support preauthorization was obtained for the disputed services (DME) as required by 28 Texas Administrative Code §134.600 (p)(12). As a result, reimbursement for the disputed charges is not recommended.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 28, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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