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

ORTHOPLUS INC
PO BOX 690633
SAN ANTONIO TX 78269

Respondent Name

PUBLIC WC PROGRAM

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1727-01

MFDR Date Received

JANUARY 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In their review they state that there was no fee schedule for the HCPCS E0218. Per the WC fee schedule the E0218 is reimbursable at $449.89 for both rental and purchase."

Amount in Dispute per Updated Table of Disputed Services: $391.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One unit of HCPCS code E0218-RR was reimbursed at $58.01 with the ANSI reduction code of 217. The other 14 units were denied with the ANSI reduction code of 151…HCPCS code E0218 is not a reimbursable code per CMS Local Coverage Determination for Cold Therapy (L11552). As such, there is no fee schedule assigned for this code. However, medical necessity was determined on preauthorization for 4 weeks and/or one month. For rental items, CMS payment is based on a monthly fee schedule. See attachment 2. One unit equals one month. Ortho Plus is billing for 15 units….The HCPCS code of E0236 was used and is described as Pump for water circulating pad. CMS reimburses 1 unit or 1 month rental of E0236 in Texas at $46.61. Reimbursement was made with an additional 125% to meet the Texas Workers' Compensation rule 134.203…HCPCS code A9999 was for the cold therapy pad and was paid as billed. HCPCS code A9901 was for DME delivery/setup. This was denied with ANSI reduction code of 97."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2011	HCPCS Code E0218- Water circulating cold pad with pump	$391.88	$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 §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-Payment is included in the allowance for another service/procedure.
   - 151-Payment adjusted because the payer deems the information submitted does not support this many services.
   - 217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
   - 217-Fair and reasonable reimbursement based on Texas fee schedule for E0236-RR. Medicare reimburses rental for 30 day period.
   - A9999-Reimbursement for pad.
   - 151-1 unit of 30 day rental reimbursed. 14 units = 14 months. Documentation does not support his many units.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 97-DME setup and delivery are global of the reimbursement for equipment.

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for HCPCS code E0218 rendered on June 29, 2011. The AMA CPT code book defines E0218 as "Water circulating cold pad with pump." The CMS reimburses HCPCS code E0218 on a monthly basis.

   Per 28 Texas Administrative Code §134.203(d) "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (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; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   Review of the Medicare DMEPOS fee schedule and the Texas Medicaid fee schedule did not contain a published fee schedule for HCPCS code E0218. As a result, the disputed service will be reviewed pursuant to 28 Texas Administrative Code §134.203 (f).

   28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 Texas Administrative Code §134.1, 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."

   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.

Former 28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that additional reimbursement of $391.88 is a fair and reasonable rate of reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for HCPCS code E0218 in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the service in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish 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 services in dispute.

Authorized Signature

		2/28/2014
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.