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
MEDME SERVICES CORPORATION

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-13-0928

Carrier's Austin Representative
Box Number 44

MFDR Date Received
DECEMBER 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This billed item was prescribed as medically necessary, approved with prior authorization # 1000951946 (see attached pre-auth document) for billed date of service 08/15/2012 in the amount of $1400.00."

Amount in Dispute: $1,400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2012	HCPCS Code L0637-NU Lumbar-Sacral Orthosis	$1,400.00	$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 §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216-Based on the findings of a review organization.

Issues

Is the requestor entitled to reimbursement for HCPCS code L0637-NU?

Findings

On the disputed date of service, the requestor billed for HCPCS code L0637-NU based upon reason code "216".

28 Texas Administrative Code §134.600(p)(9) requires preauthorization for "all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental." On August 14, 2012, the requestor obtained preauthorization approval for HCPCS code L0637.

28 Texas Administrative Code §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care)." Furthermore, 28 Texas Administrative Code §134.600(l) states, "The carrier shall not withdraw a preauthorization or concurrent review approval once issued." Because preauthorization was obtained for the disputed service a medical necessity issue does not exist for code L0637; therefore, the respondent's denial based upon code "216" is not supported

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

HCPCS code L0637 is defined as "Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise."

Per 2014 NCCI Policy Manual for Medicare Services, Chapter 12, (A) "The HCPCS Level II codes are alpha-numeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc." HCPCS code L0637 is a HCPCS Level II code. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d)(1-3) apply to the disputed service.

28 Texas Administrative Code §134.203(d)(1-3) states "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."

HCPCS code L0637 does not have a fee listed in DMEPOS fee schedule for Texas.

(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."

HCPCS code L0637 does not have a fee listed in Texas Medicaid fee schedule.

(3) "which states "if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

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, which 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.

28 Texas Administrative Code §133.307(c)(2)(O) states the request for dispute resolution shall include: "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of $1,400.00 for HCPCS code L0637 would be a fair and reasonable rate of reimbursement. As a result, payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		10/09/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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