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
ACCION REHABILITATION

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-1884-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the request for reconsideration: "It is being denied stating that authorization is needed for this claim; prior to dispensing this item we did call for benefits and were told authorization was not necessary. Due to the item being under $500.00 we were told it would be fine to dispense the cryo unit without authorization. Per rule 134.600 and 133.250 as well as ODG guidelines because the item was under $500.00 authorization should not have been necessary…"

Amount in Dispute: $584.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided a cryotherapy circulating pump and pad to the claimant on the date above then billed Texas Mutual codes E0236-NU-KX and E0218. ODG of the knee states such therapy is recommended for postoperative use after surgery general up to 7 days. The surgery took place on 11/7/12 and the unit was provided on 11/8/12. The requestor argues they were told it did not require authorization 'because the item was under $500.00…' yet the person who allegedly gave this information is not identified. The disputed amount as given by the bill in the DWC-60 pack is $584.00, an amount that requires preauthorization under Rule 134.600. No preauthorization was requested or give. [sic] No payment is due."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 8, 2012	HCPCS Code E0236-NU-KX HCPCS Code E0218	$584.00	$59.40

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 obtaining preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.

4. 28 Texas Administrative Code §134.1 sets out the guidelines for medical reimbursement. (?)
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent.
   - 762 – Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
   - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Is preauthorization required for the DME in dispute?
2. Was the DME in dispute in excess of DWC Treatment Guidelines (ODG)?
3. Is the requestor entitled to reimbursement?

Findings

1. The services were denied using denial codes 197 – "Precertification/authorization/notification absent "; 762 – "Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules" and 785 – "Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service." The respondents position summary states, "ODG of the knee states such therapy is recommended for postoperative use after surgery generally up to 7 days. The surgery took place on 11/7/12 and the unit was provided on 11/8/12." 28 Texas Administrative Code §134.600(p)(9) states that non-emergency health care requiring preauthorization includes all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental). Review of the CMS-1500 finds that the pump and water circulating cold pad were not billed in excess of the $500 allowable per item.
2. Per 28 Texas Administrative Code §134.600(p)(12) states that 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. Review of the ODG Guideline for diagnosis codes 836.0 and 836.1 finds that continuous-flow cryotherapy is one of the treatments recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use.
3. Review of the submitted documentation finds that the requestor has met the requirements of 28 Texas Administrative Code §134.600(p)(9) and (p)(12) and reimbursement will be in accordance with 28 Texas Administrative Code §134.203(d), that 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; (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."
   - HCPCS Code E0236 is described as a pump for water circulating pad. The requestor billed this code and attached modifiers NU and KX. According to Medicare pricing, data analysis and coding this HCPCS Code is considered a rental item only. Therefore, in accordance with 28 Texas Administrative Code §134.203(d) reimbursement in the amount of $59.40 ($47.52 x 125%) is recommended.
   - HCPCS Code E0218 is defined as a water circulating cold pad with pump. According to Medicare pricing, data analysis and coding this code does not appear on the CMS National Fee Schedules. Under the Texas Medicaid Fee Schedule this code is not payable; therefore since neither of these entities display a fee amount. 28 Texas Administrative Code 133.307(c)(2)(G) states, in part, that the requestor for medical fee 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) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the requestors documentation finds the requestor has not met the requirements of the rule. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $59.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $59.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 30, 2014
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.