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
Hartford Underwriters Insurance

MFDR Tracking Number
M4-14-1425-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The submitted documentation supports the billed items. The prescription has been filled and the patient has received all supplies as billed."

Amount in Dispute: $913.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier upholds denial of additional reimbursement per PLN 11 file 3/8/12 & peer report dated 4/2/13."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28 – June 28, 2013	A4595, A4557 and L0625	$913.42	$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 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4142 – The billed service has no allowance in Texas Medicaid Home Health Agency Fee Schedule
   - 193 – Original payment made on appeal/reconsideration
   - W1 – Workers compensation state fee schedule adjustment
   - 18 – Duplicate claim/service

Issues

1. Did the requestor support service payable per applicable Division rules and guidelines?

2. Is the requestor entitled to reimbursement?

Findings

1. In its response to medical fee dispute resolution, the respondent states that "The carrier submits that the treatment underlying the disputed charges was unnecessary and unrelated to the accepted contusion/abrasion injury." Applicable 28 Texas Administrative Code §133.307 (d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the Explanation of Benefits from the Carrier finds no medical necessity or extent of injury denials were used as the denial explanation code. The division concludes that the respondent raised a new denial reason. For that reason, the carrier's position, "Carrier upholds denial of additional reimbursement per PLN 11 file 3/8/12 & peer report dated 4/2/13," shall not be considered in this review.
2. The requestor states in their position that, "The submitted documentation supports the billed items. The prescription has been filled and the patient has received all supplies as billed." 28 Texas Administrative Code §134.203 (b) states, "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 Medicare policy for these services is Local Coverage Determination (LCD): Transcutaneous Electrical Nerve Stimulators (TENS) (L5031) and states, REFILL DOCUMENTATION (PIM 5.2.5-6) A routine refill prescription is not needed. A new prescription is needed when:
   - •There is a change of supplier
   - •There is a change in the item(s), frequency of use, or amount prescribed
   - •There is a change in the length of need or a previously established length of need expires

   Review of the submitted documentation finds the prescription had a length of need of six months; the unit was received on February 14, 2012. The dates of service in dispute begin February 28, 2013. Therefore, the Division finds there was no valid prescription for the services in dispute.
3. No additional payment can be recommended as provisions 28 Texas Administrative Code §134.203 (b) were not met.

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

Signature	Medical Fee Dispute Resolution Officer	September 24, 2014 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.