



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

MEDME SERVICES CORPORATION

**Respondent Name**

TWIN CITY FIRE INSURANCE CO

**MFDR Tracking Number**

M4-14-2530-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

APRIL 14, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The health care for which payment is in dispute is the TENS supplies required by the patient for monthly use and benefit. This patient has a TENS Unit that was approved for purchase by the carrier and paid by the carrier. The necessary supplies which are needed by the patient for the use of the unit during each full month of use are provided to insure the proper distribution of electrical stimulation to the effected areas, to insure proper function and use of the TENS unit which assures patient benefit. The disputed fees should be paid by the carrier as the purchase of the TENS unit warrants additional supplies as stated in: CHAPTER 43.2 Under the Medicare fee schedule of the Supplier Manual...These supplies are Medicare approved. They are separate and not included in any other billed portion of the TENS unit and the reimbursement for each of the supplies is mandated by the Medicare Fee Schedule Guidelines. The supplies for the DOS in question are not being paid according to MFS in the state of Texas. The state of Texas pays at 125% of the MAR. The submitted documentation supports the request for additional monies be paid on each DOS and on each code. A4557 pays per pair and a new pair is particularly important on a monthly basis as exposed wires from pulling on or tugging on multiple times per day would be dangerous for the patient. A4595 is for the stimulator supplies for a '2 lead unit' per month, not to be translated as 2 units of supplies per month. The unit used is a 2 lead-4 wire unit. A4630 is the 9-volt battery that generally lasts 30 days and requires regular replacement for full stimulation benefit."

**Amount in Dispute:** \$888.96

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Treatment exceeds ODG Guidelines"

**Response Submitted by:** The Hartford

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2013 September 12, 2013 October 14, 2013 November 14, 2013	HCPCS CODE A4595-NU (X4)	\$156.00	\$0.00
	HCPCS CODE A4630-NU	\$8.54	\$0.00
	HCPCS CODE A4557-NU (X2)	\$57.70	\$0.00
TOTAL		\$888.96	\$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 July 1, 2012, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 15-Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
  - 293-This procedure requires prior authorization and none was identified.
  - 18-Duplicate claim/service.
  - 181-Payment adjusted because this procedure code was invalid on the date of service.
  - 4142-The billed service has no allowance in Texas Medicaid Home Health Agency Fee Schedule.
  - 4178-The provider billed for the same supply or durable medical equipment (DME) for this patient on another bill or the provider has billed for more than one of the same supply or durable medical equipment (DME) on this bill.
  - AUTH-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Pre-authorization was not obtained and treatment was rendered without the approval of the treating doctor.
  - 247-A payment or denial has already been recommended for this service.
  - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
  - W1-Workers compensation state fee schedule adjustment.
  - 309-The charge for the procedure exceeds the fee schedule allowance.

### **Issues**

Does the disputed services require preauthorization? Is the requestor entitled to reimbursement?

### **Findings**

According to the explanation of benefits, the respondent denied reimbursement for the disputed DME supplies based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(9) states "all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)." The requestor noted that a TENS Unit was approved and purchased for the claimant. Neither party to the dispute, submitted cost information for the TENS unit to support whether or not the \$500.00 threshold had been reached.

28 Texas Administrative Code §134.600(p)(12) states "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 billed HCPCS codes A4595, A4630 and A4557 for the diagnoses 724.4-Thoracic or lumbosacral neuritis or radiculitis, unspecified, 847.2-lumbar sprain/strain, and 728.85-Spasms of muscle.

According to the Low Back Chapter of the Official Disability Guidelines (ODG), a TENS unit is not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as in conjunction with conservative treatment to restore functional restoration and reduce medication use. A review of the submitted documentation does not support that the TENS unit was used in conjunction with conservative treatment to restore functional restoration and reduce medication use. In addition, the requestor exceeded the timeframe of one-month set out in ODG; therefore, the services would require preauthorization..

The submitted documentation does not support that preauthorization was obtained for the disputed services in accordance with 28 Texas Administrative Code §134.600(p)(9) and (12). As a result, a preauthorization issue exists and reimbursement 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**

		05/27/2015
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.**