



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 Accident & Indemnity

MFDR Tracking Number

M4-15-1663-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The submitted documentation supports our request for payment on the rental of the TENS unit issued to the above –named patient."

Amount in Dispute: \$124.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As charges have exceeded \$500, pre-authorization is required for additional reimbursement of rental charge."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2014	E0730, RR	\$124.20	\$48.90

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 prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 181 – Payment adjusted because this procedure code was invalid on the date of service
 - 293 – This procedure requires prior authorization and none was identified
 - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support that additional payment is due?
2. Is the requestor entitled to reimbursement?

Findings

1. The Carrier in their review of the submitted medical claim denied the service as 293 – “This procedure requires prior authorization and none was identified. 28 Texas Labor Code §134.600 (p) Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);” Review of the submitted medical claim finds;
 - a. Date of service October 24, 2014 rental charges in the amount of \$150 submitted
 - b. Date of service November 24, 2014 purchase of the same item was submitted in the amount of \$498.00.

The Division finds as that as the above referenced rule is specific to state, “...in excess of \$500 billed charges per item (**either purchase or expected cumulative rental**), the Carrier’s denial is not supported as neither submitted claim for this item exceeded \$500.00. This service in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Labor Code §134.203 (d) states in pertinent part, “ 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;” Review of the DMEPOS fee schedule finds the following;
 - a. The Medicare, 2014, Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted code (E0730) is \$391.22
 - b. Per Medicare Claims Processing Manual, Chapter 20, 30.1.2 , “In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months”

Therefore, per the CMS instructions and Division fee guidelines, $\$391.22 \div 10 = \$39.12 \times 125\% = \$48.90$.

3. The total allowable for the services in dispute is \$48.90. This amount is 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 \$48.90.

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 \$48.90 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 16, 2015
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.