



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MEDME Services Corporation

Respondent Name

Indemnity Insurance Co

MFDR Tracking Number

M4-15-4097-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

August 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed documentation supports our request for payment of this DOS and the billed code E0730 RR."

Amount in Dispute: \$124.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that the services provided by MedMe Services is not related to the compensable injury."

Response Submitted by: ESIS P.O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2015	E0730 RR	\$124.20	\$49.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 2 – New, used, or renal identifying modifier required
 - 4 – The procedure code is inconsistent the with modifier used or a required modifier is missing
 - 8 – Billed with mod – RR
 - 402 – The appropriate modifier was not utilized

- ANS14 – The procedure code is inconsistent with the modifier used or a required modifier is missing

Issues

1. Did the carrier raise a new issue?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "It is the Carrier's position that the services provided by MedMe Services is not related to the compensable injury." Texas Administrative Code §133.307 (2) states,

Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denial related to compensability prior to the date the MFDR was filed. Therefore, the Carrier's position statement will not be considered in this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code ANS14 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Administrative Code §134.203 (b) requires that "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;"

The applicable Medicare payment policy is found at, www.cms.hhs.gov, Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), "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."

Review of the submitted information finds that the requestor submitted the service in dispute as "E0730 RR". The RR modifier is described as, "Rental (use the RR modifier when DME is to be rented)." The Division finds the insurance carrier's denial reason is not supported as the requestor did submit a one month rental as required by the Medicare Payment Policy. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code 134.203(d) 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;

The service in dispute will be calculated as follows:

- DMEPOS fee schedule 2015, Texas, E0730 (397.07) ÷ 10 (see above referenced Medicare payment policy) = \$39.70 x 125% = \$49.64

4. The total allowable reimbursement for the services in dispute is \$49.64. The carrier previously paid \$0.00 leaving a balance due to the requestor of \$49.64.

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 \$49.64.

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 \$49.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	September 15, 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, 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 MFDR 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.