



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

Universal DME LLC

Respondent Name

American Hallmark Insurance Co

MFDR Tracking Number

M4-16-0066-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is my understanding that a preauthorization is only required on items that are over \$500 per line item. We have submitted the appropriate paperwork for your review."

Amount in Dispute: \$615.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Universal DME LLC was required by division rule to obtain preauthorization for HCPCS Code E0935 since the treatment and/or services proposed exceed the commissioner's adopted treatment guidelines for the diagnosis code(s) billed. Moreover, the requestor has failed to provide sufficient evidence to substantiate that ODG criteria has been met for the use of a continuous passive motion device for treatment of the diagnoses billed. As such, per disability management rules under §137.100 the insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines. CorVel maintains the requestor, Universal DME LLC is not entitled to reimbursement for HCPCS Code E0188 (Synthetic Sheepskin Pad) based on diagnosis inconsistent with the procedure code billed."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2015	E0188, A9901, E0935	\$615.60	\$31.18

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.

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 the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 11 – Diagnosis inconsistent with procedure
 - 234 – This procedure is not paid separately
 - R38 – Included in another billed procedure
 - 197 – Payment adjusted for absence of precert/preauth

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Was prior authorization required per Division rules?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This request for dispute resolution is related to durable medical equipment provided to the injured worker in their home. The insurance carrier denied the disputed service as follows:

HCPCS Code E0188 – Synthetic Sheepskin Pad, as 11 – “Diagnosis inconsistent with Procedure.” 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;

Review of the Division rules finds no requirements related to diagnosis for the service in dispute. The Carrier’s denial is not supported. The Maximum Allowable Reimbursement will be calculated per applicable fee guidelines.

HCPCS Code A9901 – DME delivery, set up, and/or dispensing service component of another HCPCS code was denied as 234 – This procedure is not paid separately. Medicare Claims Processing Manual, Chapter 20, Section 60, Payment for Delivery and Service Charges for Durable Medical Equipment, “Delivery and service are an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. Such costs are ordinarily assumed to have been taken into account by suppliers (along with all other overhead expenses) in setting the prices they charge for covered items and services. As such, these costs have already been accounted for in the calculation of the fee schedules. Also, most beneficiaries reside in the normal area of business activity of one or more DME supplier(s) and have reasonable access to them. Therefore, DME carriers may not allow separate delivery and service charges for oxygen or DME except as specifically indicated in §§90 or in rare and unusual circumstances when the delivery is not typical of the particular supplier's operation.”

Review of the submitted documentation finds insufficient evidence to support rare and unusually circumstances that would allow separate reimbursement for the delivery of the durable medical equipment. The carrier’s denial is supported.

2. The carrier denied HCPCS code E0935 as 197 – “Payment adjusted for absence of precert/preauth and ODG – “Services exceed ODG guidelines;preauth is required.” Review of the June 2015 ODG guidelines finds;
 - i. Continuous passive motion (CPM) - Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures:
 - (1) Total knee arthroplasty (revision and primary)
 - (2) Anterior cruciate ligament reconstruction (if inpatient care)

(3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005)

ii. For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight:

(1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with:

(a) complex regional pain syndrome;

(b) extensive arthrofibrosis or tendon fibrosis; or

(c) physical, mental, or behavioral inability to participate in active physical therapy.

(2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies.

Review of the submitted documentation finds:

- Diagnosis Code found in 21 (A) – 844.9 – Sprain and strain of unspecified site of knee and leg and 836.0 – Tear of medial cartilage or meniscus of knee, current

Based on the above, the carrier's denial is supported. The ODG guidelines were exceeded therefore prior authorization should have been obtained.

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;

The maximum allowable reimbursement for HCPCS Code E0188 –NU found on www.dmedpac.com for the date of service is \$24.94. This amount (\$24.94) x 125% = \$31.18. This amount is recommended.

4. The total recommended payment for the services in dispute is \$31.18. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$31.18. 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 \$31.18.

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 \$31.18 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

October , 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, 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.