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

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-16-0138-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received a denial on 08/26/2015 stating that all original decision s were being maintained except for E0218 was paid in the amount of $63.24. Texas Workers Compensation claims are to be reimbursed at 125% of the Medicare allowable rate. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 3rd quarter 2014, E0218 RR is supposed to be reimbursed at $60.44 per unit a 125%. For codes E0675 and E0673, it is my understanding that per the rule 134.600 that we do not need authorization for this DME and for code E0217 we did have authorization.

Amount in Dispute: $1,402.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves three separate pieces of durable medical equipment billed as E0218, E0675, and E0673. E0218 was paid pursuant to the Medicare fee guidelines; therefore, no additional reimbursement should be owed for this item. E0675 and E0673 have been denied. The items were not prescribed, nor used, in accordance with the Official Disability Guidelines (ODGs). Therefore, DWC Rule 134.600(p)(12) applies to these items as their use falls outside of the ODGs, and preauthorization was required. Because preauthorization was not obtained, payment for the items is not owed."

Response Submitted by: Downs ♦ Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2015	E0218, E0675, E0673	$1, 402.76	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets forth general provisions related to professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - ODG – Services exceed ODG guidelines; preauth is required
   - P12 – Workers' Compensation State Fee Schedule Adj
   - 107 – Denied – qualifying svc not paid or identified
   - RA6 – procedure Billing Restricted/Once per 30 days
   - W3 – Appeal/Reconsideration

Issues

1. Was prior authorization required?
2. What is the fee guideline line?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to durable medical equipment. The carrier denied codes E0675 -RR and E0673 –NU as ODG – "Services exceed ODG guidelines; preauth is required and 197 – "Payment adjusted for absence of pecert/preauth." Review of the submitted documentation finds;

   a. ODG, June 2015 Guidelines: "Lymphedema pumps, Recommend home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garments."

   b. Place of service on 1500 claim form, 24(B), is 22 – "Outpatient hospital" not the injured worker's home

   c. Medical record finds insufficient evidence of conservative medical management

   Based on the above, ODG guidelines were exceeded. 28 Texas Administrative Coder 134.600(p)(12) states,

   > Non-emergency health care requiring preauthorization includes:
   >
   > (12) 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 carrier's denial is supported no additional payment can be recommended.

2. The submitted code E0218 – RR, "Water circulating cold pad with pump." 28 Texas Administrative Code §134.230(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; or

   No DMEPOS fee schedule was found for this date of service. The rental fee found at the Texas Medicaid website or, www.tmph.com/feeschedule is $36.05. This amount multiplied by 125% = $45.06. The requestor indicates "7" units but insufficient evidence was found to support a daily rental is allowed by Medicare or Medicaid for this procedure.

3. The maximum allowable reimbursement for the service in dispute is $45.06. The carrier paid $63.24. No additional payment can be 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

		October 14, 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.