TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
City of Midland

MFDR Tracking Number
M4-16-0235-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
September 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental). We did receive authorization #77694 before services were rendered. It is my understanding that a preauthorization is only required on items that are over $500 per line item. We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: $1,699.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that the denial of these services were correct based on lack of preauthorization and/or retrospective review, as per ODG guidelines, and that no reimbursement is due."

Response Submitted by: Claims Administrative Services, Inc. 501 Shelley Drive, Tyler, Texas 75701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 21, 2015	E0673, E0675, L3670, A9901, E0217	$1,699.02	$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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §133.240 sets out guidelines for medical payments and denials.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - B15 – This service/procedure requires that a qualifying service/procedure be received and covered
   - 216 – Based on the findings of a review organization
   - W3 – In accordance with DI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute are for durable medical equipment. The carrier denied for multiple denial codes. The following is a detailed review of these denials and the applicable rules.

   - Procedure code E0673 – NU, "Segmental gradient pressure pneumatic appliance, half leg" and E0675 – RR, "Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)" was denied with denial code 216 – "Based on the findings of a review organization." Review of the submitted documentation finds;

     - Retrospective Utilization Review Adverse Determination dated 08/26/2015 from Review Med

     - Office of Disability Guidelines Treatment Guidelines, "Compression garments Not generally recommended in the shoulder."

     - 28 Texas Administrative Code 134.240 states,

       (p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

       (q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

     - The IRO contacted Dr. Beman on 08-25-2015 to discuss the case.

     - Requirements of Rule 134.240 met. Treatment guidelines exceeded, prior authorization was required.

- Procedure code L3670-RT "Shoulder orthosis," and E0217-RR "Water circulating heat pad with pump" were denied as 197 – "Precertification/authorization/ notification absent" 28 Texas Administrative Code 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);

  Review of the "Utilization Review" from ReviewMed dates July 17, 2015 finds;

- "The medical necessity of the 7-day rental of a cold therapy unit is Certified
- The submitted code, E0217, has a narrative of "Water circulating heat pad with pump".

The carrier's denial is supported as the submitted code was for a "Heat pump" not the certified "Cold Pump".

- The submitted code, L3670 –Rt, "The medical necessity of the postoperative abduction splint is Not Certified." ODG on shoulder states, "postoperative abduction pillow sling, Recommended as an option following open repair of large and massive rotator cuff tears and other shoulder surgeries." Review of the submitted documentation finds insufficient information to support repair of large and massive rotator cuff tear was required.

The carrier's denial is supported as the submitted code exceeds ODG guidelines thus required authorization that was denied prior to service being provided.

- Procedure code A9901 – "DME delivery, set up" was denied with B15 – "This service/procedure requires that a qualifying service/procedure be received and covered." Review of the Medicare Claims Processing Manual, Chapter 20, 60, "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."

The insurance carrier's denial reason is supported as insufficient information was found to support a rare and unusual circumstance made charging a delivery fee necessary. Additional reimbursement cannot be recommended.

2. The Division finds the Carriers denials are supported as requirements of Rule 134.203 and 134.600 were not met. No additional payment is 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 , 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.