



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

MEDME SERVICES CORPORATION

MFDR Tracking Number

M4-16-0349

MFDR Date Received

October 9, 2015

Respondent Name

EL PASO COUNTY

Carrier's Austin Representative

Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid because the purchase of the unit warrants additional supplies. The TENS unit was approved and authorized for purchase with pre-auth number PFXXXXXX. The supplies include electrodes, batteries and lead wires. The batteries and lead wires are not being paid as not medically necessary. However, the TENS was deemed medically necessary and the TENS will not operate without additional monthly supplies thereby deeming the supplies as medically necessary as well."

Amount in Dispute: \$470.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 19, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include service periods from October 2014 to March 2015 and a total row.

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 Preauthorization, Concurrent Utilization Review, and Voluntary Certification 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:
  - 50B – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \*Medical Necessity for the service(s)/procedure has not established; please forward substantiating documentation to the carrier.\*
  - W3 – Reconsideration/Appeal
  - 97G – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. \*Supplies are included in the rental/purchase.\*
  - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers’ Compensation State Fee Schedule.
  - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. \*Service(s)/Procedure is included in the value of another service/procedure billed on the same date.\*

## **Issues**

1. Does the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity, for date of service January 26, 2015?
2. Is the insurance carrier’s denial or reduction of payment supported?
3. What is the applicable rule for reimbursement?
4. Is the requestor entitled to reimbursement?

## **Findings**

1. Review of the submitted EOB’s for date of service January 26, 2015, supports that the insurance carrier denied/reduced HCPCs Level II codes A4630 and A4557 with denial reason code “50B – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. \*Medical Necessity for the service(s)/procedure has not established; please forward substantiating documentation to the carrier.\*”

Review of the submitted documentation finds that the medical fee dispute referenced for date of service January 26, 2015, contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute.

The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at [http://www.tdi.texas.gov/hmo/iro\\_requests.html](http://www.tdi.texas.gov/hmo/iro_requests.html) under **Health Care Providers or their authorized representatives**.

28 Texas Administrative Code §133.305(b) requires that “If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

The medical fee dispute for date of service January 26, 2015, may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The Division finds that due to the unresolved medical necessity issues for date of service, January 26, 2015, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division

finds that date of service, January 26, 2015, is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

2. The requestor seeks payment for HCPCS Level II Codes, A4630-NU and A4557-NU rendered on, October 22, 2014 through December 24, 2014, February 26, 2015 and April 27, 2015. The insurance carrier denied the disputed services with claim adjustment reason code “97G – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. \*Supplies are included in the rental/purchase” and “97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. \*Service(s)/Procedure is included in the value of another service/procedure billed on the same date.”

28 Texas Administrative Code §134.203 (b), states in pertinent part, “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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

The AMA CPT Code Book defines HCPCS Level II Code as follows:

A4630 – Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient.

A4557 – Lead wires (e.g., apnea monitor), per pair.

A4595 – Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)

The requestor appended modifier “NU- New equipment” to HCPCS Codes A4630 and A4557. The insurance carrier issued payment for HCPCS Level II code A4595 and the requestor seeks reimbursement for A4630-NU and A4557-NU.

The applicable Medicare Coding Guidelines when billing HCPCS Code A4630 is as follows:

“A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation material, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if recharger batteries were used).”

The requestor seeks payment for A4630-NU, which is bundled into HCPCS code A4595, previously paid by the insurance carrier. As a result, reimbursement cannot be recommended for HCPCS Level II code A4630-NU rendered on October 22, 2014 through December 24, 2014, February 26, 2015, March 26, 2015 and April 27, 2015.

The applicable Medicare Coding Guidelines when billing HCPCS Codes A4557 is as follows:

“Replacement of lead wires (A4558) more often than every 12 months would rarely be... necessary.” As a result, reimbursement cannot be recommended for HCPCS Level II code A4557 rendered on October 22, 2014 through December 24, 2014, February 26, 2015 and April 27, 2015.

For HCPCS Level II code A4557 rendered on March 26, 2015, the requestor submitted documentation to support that the TENS unit was received on March 25, 2014. Based on the applicable Medicare payment policy, date of service March 26, 2015 is 12 months after the unit was received. This date of service will be reviewed per applicable rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, “(d) 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 (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

The Medicare reimbursement for HCPCS Code Level II Codes A4557-NU is  $\$23.08 \times 125\% =$  MAR amount of  $\$28.85$ . The requestor seeks  $\$58.58$ , the lesser of is  $\$28.85$ , therefore this amount 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  $\$28.85$ .

**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 \$28.85 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

December 10, 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.***