



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 LLC

Respondent Name

AMERICAN INTERSTATE INSURANCE COMPANY

MFDR Tracking Number

M4-16-0630-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 09/11/2015 we received a denial for no precertification/authorization. On 09/23/2015 we sent an appeal... 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: \$913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "File documentation note 9/10/15 'denied DME' and Venaflow System online product descriptions are enclosed. Combined value purchase of \$414.00 plus rental \$499.00 equals \$913.00 which value exceeds \$500.00 threshold, so precertification was required. Carrier continued to deny medical benefits based on lack of required precertification for the Venaflow items."

Response Submitted by: Amerisafe Risk Services, Inc.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 11, 2015, E0675-RR and E0673-NU, \$913.00, \$871.06

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 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care
3. 28 Texas Administrative Code §134.203 sets out the Medical Fee Guideline for Professional Services

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - RC 03 – The procedure or supply requires prior authorization or approval.
 - 197 – Precertification/authorization/notification absent.
 - W3 – Additional payment made on appeal/reconsideration.
 - RC@G – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What is the AMA CPT Code Description for HCPCS Level II Codes E0675-RR and E0673-NU?
2. Do HCPCS Code Level II Codes E0675 and E0673 require preauthorization?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for HCPCS Level II Codes E0675 and E0673 denied reduced by the insurance carrier with claim adjustment reason codes “RC 03 – The procedure or supply requires prior authorization or approval,” and “197 – Precertification/authorization/notification absent.”

28 Texas Administrative Code §134.203 states, “(b) 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 Codes E0675 as “Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)” and HCPCS Level II Codes E0673 as “Segmental gradient pressure pneumatic appliance, half leg.”

The Requestor appended modifier RR to HCPCS Level II Code E0675 defined by CGS Medicare as “Rental.”

The Requestor appended modifier NU to HCPCS Level II Code E0673 defined by CGS Medicare as “Purchase of new equipment. Only use if new equipment was delivered.”

Per CGS Medicare “PCDs used ... are coded: E0675 - PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE, FOR ARTERIAL INSUFFICIENCY (UNILATERAL AND BILATERAL SYSTEM). Sleeves used with E0650 - E0652 and E0675 are billed separately using codes E0655 - E0673 depending upon the specific item provided.” The Division finds that the requestor billed per CGS Medicare guidelines, as a result the disputed services are reviewed pursuant to the applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.600 states in pertinent part, “(p) Non-emergency health care requiring preauthorization includes... (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental).”

Review of the submitted information finds that that the requestor appended modifier RR to HCPCS Level II Code E0675 to identify that this service was a rental and billed the insurance carrier the amount of \$499.00. The insurance carrier submitted insufficient documentation to support that the cumulative rental exceeded \$500.00 for HCPCS Level II Code E0675-RR.

The requestor appended modifier NU to HCPCS Level II Code E0673 to identify that this service was a purchase and billed the insurance carrier the amount of \$414.00. The Division finds that the insurance carrier’s denial reason is not supported as the billed charges per item is not in excess of \$500.00. The disputed services will therefore be reviewed per applicable Division 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 Level II Code E0675-RR is $\$426.83 \times 125\% = \text{MAR of } \533.54 . The Requestor seeks reimbursement in the amount of $\$499.00$ as a result, this amount is recommended.

The Medicare reimbursement for HCPCS Level II Codes E0673-NU is $\$297.65 \times 125\% = \text{MAR of } \372.06 . The requestor seeks $\$414.00$, the lesser of is $\$372.06$, therefore this amount is recommended.

The Division finds that the requestor is entitled to a total recommended reimbursement amount of $\$871.06$. Therefore, 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 $\$871.06$.

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 $\$871.06$ plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	December 10, 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.