



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

Texas Mutual Insurance

MFDR Tracking Number

M4-16-1152-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: \$288.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position that no additional payment is due for the reasons given on its EOBs."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 2015	E1399, A9901, E0190	\$288.00	\$59.99

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 §137.100 details concepts of disability management.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 762 – Denied in accordance with 134.600 (p)(12) treatment/service in excess of DWC treatment guidelines (ODG)
 - 217 – The value of this procedure is included in the value of another procedure performed on this date.
 - 891 – No additional payment after reconsideration.
 - 193 – Original payment decision is being maintained.

Issues

1. Is the delivery/set up charge billed as A9901 separately payable?
2. Is the carrier's denial supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed service A9901 with claim adjustment/ reason code 217 – “The value of this procedure is included in the value of another procedure performed on this date.” 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 applicable Medicare Policy is found at www.cms.hhs.gov, Claims Processing Manual, Chapter 4, Section 60,

Payment for Delivery and Service Charges for Durable Medical Equipment, (Rev. 1, 10-01-03) B3-5105

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.

For example, there may be situations in which it is necessary for a DME dealer to incur extraordinary delivery expenses in order to meet the needs of beneficiaries living in remote areas that are not served by a local dealer or when a local dealer is temporarily out of stock of required oxygen or equipment. For example, DME carriers may recognize a reasonable separate delivery charge when the supplier must deliver an item of DME outside its normal area of business activity and the beneficiary does not have access to a supplier whose location is nearer.

When a supplier delivers oxygen or DME outside the area in which he/she normally does business, but the item could have been obtained locally, carriers may allow any separate additional delivery charge only to the extent that it does not raise the total payment for the oxygen or DME above the local fee schedule.

When a separate charge can be allowed for delivery/service, carriers base the amount (based on mileage or a flat rate) on all of the relevant circumstances, including:

- *The time and distance traveled;*

- *The actual additional expenses incurred by the supplier;*
- *The type and quantity of equipment or oxygen delivered;*
- *The supplier's customary charge under such circumstances;*
- *The prevailing charges in the locality under such circumstances; and*
- *Delivery charges made elsewhere in similar localities. Any separate delivery charges recognized because of unusual circumstances may, of course, be paid for only for deliveries that have actually been made.*

Suppliers must be advised in the carrier service areas to bill a separate delivery charge only in those rare situations in which "unusual circumstances" were encountered. Information issuances should be used to advise DME suppliers of the need to fully document unusual circumstances on claims/bills for separate delivery charges. If a supplier, nevertheless, routinely itemizes delivery charges, carriers may consider payment for the charges to be included in the fee for the equipment.

Review of the submitted documentation finds insufficient information to support that "unusual circumstances" required a separate charge for the delivery of the durable medical equipment. The carrier's denial is supported.

2. The carrier denied the disputed service E0190 as 762 – "Denied in accordance with 134.500(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules. 28 Texas Administrative Code §137.100 (e) and (g) state,

An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

The insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

Review of the submitted documentation finds insufficient evidence to support a retrospective review compliant with Rule 137.100(e) was performed. The carrier's denial is not supported. The service E0910 will be reviewed per applicable rules and fee guidelines.

3. The services that remain in dispute are E0190 and E1399. 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;
- (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.

For code E0190 no allowable was found in the DMEPOS fee schedule. Review of the Texas Medicaid fee schedule found and allowable of \$47.99. Pursuant to the above the maximum allowable reimbursement is calculated at (\$47.99 x 125% = \$59.99). This amount is recommended.

For code E1399 no allowable was found in the DMEPOS fee schedule. Review of the Texas Medicaid fee schedule also found no allowable. Therefore Rule 134.203(d)(3) applies.

28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this

title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1(f) states,

Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how reimbursement of \$99.00 for code E1399 -NU is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

4. The total allowable for the services in dispute is \$59.99. 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 \$59.99.

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 \$59.99 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

January , 2016
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.