



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-1281-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 11/02/2015 we submitted our claim for payment to ESIS in the amount of \$135.00 via fax 855-496-5410. On 11/05/2015 we received a denial for incorrect modifier, which indeed we did bill with the correct modifier."

Amount in Dispute: \$135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bill was sent for processing. It was determined that no additional payment is owed to the provider."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 28, 2015, E0730 RR, \$135.00, \$49.64

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 out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 1 - Billed with modifier RR
- 3 - New, used, or rental identifying modifier required

- 5 – 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- 7 – A technical bill review (TBR) has been performed
- Note: This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 4 – “The procedure code is inconsistent with the modifier used or a required modifier is missing.” 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 found at, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf> Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), which states;

*In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to **the two months rental.***

Review of the submitted medical claim finds the code submitted is E0730 –RR. As this was the first month, the carrier’s denial is not supported. The service in dispute will be reviewed per applicable fee guideline.

2. 28 Texas Administration Code 134.203 (d)(1) 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;

The 2015 4th quarter DMEPOS Fee Schedule for E0730 RR is $(397.09 \div 10 = \$39.71)$ $\$39.71 \times 125\% = \49.64

3. The total allowable for the services in dispute is \$49.64. The carrier previously paid \$0.00. The remaining balance of \$49.64 is due to the requestor.

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 \$49.64.

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 \$49.64 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

February , 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.