



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UNIVERSAL DME, LLC

Respondent Name

NETHERLANDS INSURANCE CO

MFDR Tracking Number

M4-16-1551-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

FEBRUARY 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All durable medical equipment (DME) in excess of \$500.00 billed charges per item (either purchase or expected cumulative rental), even though we did have authorization from them #12100545 before these services were rendered. It is also my understanding that a preauthorization is only required on items that are over \$500 **per line item** in which these are not over that amount."

Amount in Dispute: \$461.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2015	HCPCS Code E0731-NU Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)	\$461.59	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for specific treatments and services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 198-Precertification/authorization exceeded
 - MA04-Number of Occurrences on Authorization record has been exceeded.
 - 18-Duplicate claim/service.
- 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 February 12, 2016. 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.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed DME code E0731 based upon a lack of preauthorization.

28 Texas Administrative Code §134.600(p)(9) states "all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)."

The requestor states "All durable medical equipment (DME) in excess of \$500.00 billed charges per item (either purchase or expected cumulative rental), even though we did have authorization from them #12100545 before these services were rendered. It is also my understanding that a preauthorization is only required on items that are over \$500 per line item in which these are not over that amount." In support of the position, the requestor submitted a copy of the October 15, 2015, preauthorization approval report for one (1) month rental of TENS unit w/muscle stimulator. The Division finds that this preauthorization approval was not for the purchase of the disputed DME, code E0731-NU.

Texas Administrative Code §134.600(p)(12) states "Non-emergency health care requiring preauthorization includes: 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 carrier."

28 Texas Administrative Code § 137.100(f) states "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

The requestor billed HCPCS codes E0731 for the diagnoses S83.91XA found in the knee and lower leg.

According to the Knee and Leg Chapter of the Official Disability Guidelines (ODG), HCPCS code E0731 is not a treatment or service included or addressed in the ODG; therefore, the disputed HCPCS code E0731, required preauthorization. As a result, a preauthorization issue exists and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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


Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

4/15/2016
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, 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.