



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

STAR INSURANCE CO

MFDR Tracking Number

M4-16-1622-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

February 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we received a denial from Gallagher Bassett stating they are 'not correct payer', when indeed they are and we have provided supporting documentation for your review."

Amount in Dispute: \$135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed . . . Per bill review department, additional allowance was recommended. An adjustment has been processed and . . . (additional \$59.76) was finalized in our system today."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2015	TENS four lead (1 month rental) HCPCS Code E0730	\$135.00	\$0.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Services to be reviewed for payment by DME informal or voluntary network, Coventry DMEplus, as defined in Texas Labor Code 408.0284. Contact DMEplus at dmebilling@cvt.com or (877)398-9938 with inquiries. (XX90)

- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. (ZD86)
- W3 – Request for reconsideration (ZE10)
- 10 – (109) CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR

Issues

1. Is the disputed service subject to a contractual fee schedule?
2. What is the recommended reimbursement for the disputed durable medical equipment?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The submitted explanation of benefits indicates that services were to be reviewed for payment by a DME informal or voluntary network as defined in Texas Labor Code 408.0284. Documentation was not presented to support a contracted fee schedule or applicable contract between the health care provider and the insurance carrier or a network in accordance with the requirements of Labor Code 408.0284. Consequently, reimbursement for the disputed service will be reviewed in accordance with Division rules and fee guidelines.
2. This dispute regards durable medical equipment rental with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(d), which requires that 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

Additionally, subsection §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The Medicare payment policy applicable to rental of TENS equipment is found in *Medicare Claims Processing Manual*, CMS Publication 100-04, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), §30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS), which states that:

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.

Per Medicare's DMEPOS fee schedule, HCPCS code E0730 is assigned payment class TE for TENS equipment; therefore, the above Medicare payment policy applies to this code. Review of the submitted documentation finds the disputed service is for one month's rental of TENS equipment. The Medicare DMEPOS fee schedule purchase price is \$397.09. One month's rental amount is ten percent of the purchase price, or \$39.71. The MAR is 125 percent of this amount or \$49.64.

3. The total allowable reimbursement for the service in dispute is \$49.64. The insurance carrier has paid \$59.76. No additional payment 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 \$0.00.

ORDER

Based on 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 additional reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>June 7, 2016</u>
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.