



# 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 CO

**MFDR Tracking Number**

M4-16-2828-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 16, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The patient has had the tens unit for code E0730 since 07/01/2015 and the codes A4595, and A4630 are supplies that go with the tens unit. On 04/15/2016 we sent our appeal for payment. On 05/09/2016, our appeal was denied again stating same reason for all codes... We feel that these charges are due to us as you will see in our supporting documentation."

**Amount in Dispute:** \$55.75

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The TENS unit of 7/1/15 was preauthorized by Texas Mutual on 6/25/15... That authorization as for one month trial rental... What is more, Texas Mutual has not received any further preauthorization request for a TENS, rental, purchase, or otherwise. Nor has the requestor provided any evidence of such with its DWC60. For this reason Texas Mutual declined to issue payment for TENS supplies some ten months after the expiration of the one month TENS trial rental of July 2015. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 22, 2016	A4630 and A4595	\$55.75	\$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**

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 fee guideline for durable medical equipment.

#### **Issues**

1. Did the insurance carrier raise new denial reasons or defenses after the submission of the MDR request?
2. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203 (b)?
3. Is reimbursement due?

## Findings

1. The requestor seeks reimbursement for DME services supplied to the claimant on February 22, 2016. The insurance carrier denied/reduced the disputed services with denial/reduction code(s); "CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment, CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication, 225 – The submitted documentation does not support the service being billed, we will re-evaluate this upon receipt of clarifying information, 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions, CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly, 891 – No additional payment after reconsideration."

The respondent's position statement asserts "Texas Mutual has not received any further preauthorization request for a TENS, rental, purchase, or otherwise. Nor has the requestor provided any evidence of such..." Former Texas Labor Code §408.027(d) [currently 408.027(e)], Acts 1993, 73rd Legislature, chapter 269, effective September 1, 1993, requires that "If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the commission [now the Division], the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee."

28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

No documentation was found to support that the insurance carrier sent the required report containing sufficient explanation of the above reason(s) for the reduction or denial of payment. The Division concludes that the respondent has not met the requirements of §408.027. This denial reason raised in the insurance carrier's position summary pertaining to preauthorization is not supported. As a result, the disputed services are reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (b), states in pertinent part, "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 the following HCPCS Level II codes as follows:

A4630 – Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient

A4595 – Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)

The requestor appended modifier "NU- New equipment" to HCPCS codes A4630 and A4595.

Per [www.cms.hhs.gov](http://www.cms.hhs.gov) Local Coverage Determination (LCD) ID L5031, LCD Title Transcutaneous Electrical Nerve Stimulators (TENS); Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is: 2 TENS leads - a maximum of one unit of A4595 per month, 4 TENS leads - a maximum of two units of A4595 per month." "Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a 3-month quantity at a time."

The applicable Medicare Coding Guidelines when billing HCPCS Code A4630 is as follows:

"A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation material, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if recharger batteries were used)."

The requestor seeks payment for A4630-NU, which is bundled into HCPCS code A4595, previously paid by the insurance carrier. As a result, reimbursement cannot be recommended for HCPCS Level II code A4630-NU rendered on February 22, 2016.

The Requestor seeks reimbursement for HCPCS code A4595-NU. Review of the preauthorization letter indicates that the TENS unit was preauthorized for one month trial use. Per LCD noted above, a maximum of one unit of A4595 per month is recommended. The requestor submitted insufficient documentation to support that the tens unit was prescribed longer than the one month trial period. As a result, reimbursement cannot be recommended for the disputed services.

3. The Division finds that due to the insufficient documentation submitted by the requestor reimbursement for HCPCS code A4595-NU cannot be 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 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

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
June 3, 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.**