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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Worth Casualty Co

MFDR Tracking Number
M4-16-3857-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not need authorization for this item per the rule 134.600. We fixed the HCPCS Code for E30217 to E0128. On 07/05/2016 we sent our appeal for payment including all proper documentation including authorization #80709582-umo-6 for Code E0218. On 08/05/2016 our appeal was paid a partial payment for code E0218 in the amount of $45.06, they denied codes E0675, E0673 for all the same reasons."

Amount in Dispute: $1,420.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Regarding HCPCS codes E0675 and E0673, the Requestor disagree that preauthorization was not required simply because of the billed charges. While rule 134.600(p)(9) indicates DME exceeding $500 requires preauthorization, rule please refer to Rule 137.100(d) that indicate the carrier is not liable for treatment and/or services provided in excess of the Division's treatment guidelines unless for emergency care or is preauthorized. This authorized the use of ODG."

"Regarding HCPCS code E0217... The requestor corrected their billing to reflect the cryotherapy unit by billing E0218. …The submitted code should be considered as a monthly rental. Because this service is reimbursable per month rather than per day the allowed number of units will be one."

Response Submitted by: CorVel Healthcare Corporation, 10000 North Central Expressway, Ste 300, Dallas, TX 75231

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2016 to March 28, 2016	E0218 – RR	$507.94	$0.00
March 22, 2016	E0675 – RR	$499.00	$0.00
March 22, 2016	E0673 – NU	$414.00	$0.00
		$1,420.94	

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 134.600 sets out the requirements of prior authorization of medical service.
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:
   - 107 – Denied-qualifying svc not paid or identified
   - 197 – Payment adjusted for absence of precer/preauth
   - 198 – Preauthorization exceeded
   - 234 – This procedure is not paid separately
   - NU – New Equipment
   - ODG – Services exceed ODG guidelines: preauth is required
   - P12 – Workers' compensation state fee schedule adj
   - R38 – included in another billed procedure
   - RR – Rented Equipment
   - RA6 – Procedure Billing Restricted/Once per 30 days
   - 193 – Original payment decision maintained
   - W3 – Appeal/reconsideration
   - ZZ – Rule review completed

Issues

1. Is the carrier's denial supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requester seeks reimbursement in the amount of $499.00 for code E0675 – "Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)."

   The carrier denied the submitted code as, 197 – "Payment adjusted for absence of precert/preauth."

   28 Texas Administrative Code §134.600(p)(12) states in pertinent part,

   > Non-emergency health care requiring preauthorization includes:
   >
   > > (12) 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 insurance carrier.

   28 Texas Labor Code §137.100 (a) states in pertinent part,

   > Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines – Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning).

   Review of the Official Disability Guidelines (ODG) finds;

   a. Lymphadema pump (pneumatic compression device) "Recommend home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garment"

Review of the submitted medical bill finds the following;

a. Place of service submitted was “22” or Outpatient hospital

b. Submitted diagnosis codes were S8392XA – “Sprain of unspecified site of left knee, initial encounter”

The requirements of Rule 134.600(p)(12) were not met as the reported diagnosis and place of service are not addressed in the ODG guidelines thus requiring prior authorization. No additional payment can be recommended.

The carrier denied the submitted code E0673 as 107 – “Denied – qualifying svc not paid or identified.” Review of the submitted code E0673 is described as “Segmental gradient pressure pneumatic appliance, half leg: the qualifying service being the compression device was not paid. Therefore, the carrier’s denial of the supply is supported.

The service in dispute HCPCS Code E0218 – “Water circulating cold pad with pump.” The health care provider added the “RR” modifier to indicate rental of the durable medical equipment.

The requestor is seeking additional reimbursement in the amount of $414.00. The carrier made a payment of $45.06 and explained this reduction as “P12-Workers’ compensation jurisdictional fee schedule adjustment” and RA6 – “Procedure billing restricted/once per 30 days.”

28 Texas Labor Code §134.203(d) states in pertinent parts,

> 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;

Review of the 2016 1st Quarter Texas DMEPOS Fee Schedule found at www.cgs.medicare.com, shows no fee schedule allowable for code E0218. Therefore, there is no Medicare published rate under DMEPOS.

Because there is no published rate under Medicare DMEPOS, the Division looks to the Texas Medicaid fee schedule found at www.tmhp.com as described under §134.203(d)(2) above.

Texas Medicaid indicates that a rental for code E0218 has a total allowable of $36.05.

Therefore, per 28 Texas Labor Code 134.203(d)(2), the applicable fee schedule amount is $36.05. This amount multiplied by 125% = $45.06

2. The maximum allowable for the services in dispute is $45.06. The carrier previously paid $45.06. 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 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 21, 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.