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
DURAMED, INC.

Respondent Name
PA MANUFACTURERS ASSOCIATION INSURANCE COMPANY

MFDR Tracking Number
M4-18-4392-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**Per TWCC rule 134.600(p)(12)** durable medical equipment requires preauthorization only when a single item **EXCEEDS %500**."

Amount in Dispute: $877.00

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 30, 2017 to December 1, 2017	Durable Medical Equipment	$877.00	$852.00

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 professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
5. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged July 30, 2018. 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 has not responded. Accordingly, this decision is based on the information available at the time of review.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution?
2. Was preauthorization required?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier's Austin representative acknowledged receipt of the dispute notification on July 30, 2018. However, the insurance carrier has not responded. 28 Texas Administrative Code §133.307(d)(1), states, "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." Accordingly, this decision is based on the information available at the time of review.
2. The insurance carrier denied disputed services with claim adjustment reason codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT

   28 Texas Administrative Code §134.600 sets out requirements regarding preauthorization of health care.

   Rule §134.600(p)(9) states that non-emergency health care requiring preauthorization includes:

   all durable medical equipment (DME) in excess of $500 billed charges per item

   Review of the submitted medical bills finds that all of the disputed items are durable medical equipment; however, none of the disputed charges for any item is in excess of $500.00.

   The insurance carrier did not submit a response for consideration in this review.

   No information was found to support that the disputed items required preauthorization.

   Based on the submitted information, the insurance carrier has failed to support its denial reasons. Consequently, the disputed services will be reviewed for reimbursement in accordance with division rules and fee guidelines.
3. This dispute regards durable medical equipment with reimbursement subject to the *Medical Fee Guideline for Professional Services*, 28 Texas Administrative Code §134.203(d) which requires that the maximum allowable reimbursement (MAR) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be (1) 125% 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% of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies; or (3) if neither paragraph (1) nor (2) apply, then as calculated according to Rule §134.203(f), requiring that reimbursement be provided in accordance with 28 Texas Administrative Code §134.1.

   Rule §134.203(h) requires that reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, (3) fair and reasonable amount consistent with the standards of Rule §134.1.

   Reimbursement is calculated as follows:

   - For HCPCS code E0215, November 30, the Medicare DMEPOS fee is $78.87. 125% of this amount is $98.59.
   - For HCPCS code L0642, November 30, the Medicare DMEPOS fee is $396.73. 125% of this amount is $495.91.
   - For HCPCS code E0730, November 30, the Medicare DMEPOS fee is $59.00. 125% of this amount is $73.75.
   - For HCPCS code A9150, neither Medicare nor Texas Medicaid assign a fee or relative value for this item. Per Rule §§ 134.203(d)(3) and (f), payment is subject to Rule §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $0.00. Review of the submitted documentation finds insufficient information to support a different amount from that paid by the carrier; additional reimbursement cannot be recommended.
   - For HCPCS code A4595, November 30, 2017, represents equipment or supplies paid per Rule §134.203(d). The Medicare DMEPOS fee is $10.03. 125% of this amount is $12.54 at 4 units is $50.16.

- For HCPCS code E0190, Medicare has not assigned a fee or relative value in the DMEPOS fee schedule. However, Texas Medicaid assigns a fee of $52.16. 125% of this amount is $65.20. Per Rule §134.203(h), reimbursement is the lesser of the MAR or the provider's charge. The lesser amount is $35.00.
- For HCPCS code E0215, December 1, the Medicare DMEPOS fee is $78.87. 125% of this amount is $98.59.

4. The total allowable reimbursement for the disputed services is $852.00. The insurance carrier paid $0.00. The amount due is $852.00. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the available evidence presented by the requestor and respondent at the time of review. Even though not all the evidence was discussed, it was considered.

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 $852.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $852.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 19, 2018
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.