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
American Casualty Co of Reading PA

MFDR Tracking Number
M4-19-0488-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
September 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above date of service was not paid and has been returned due to reason: "Payment adjusted for absence of precert/preauth." This is incorrect. Per TWCC rule 134.600 (p)(12) durable medical equipment requires preauthorization only when a single item exceeds $500. None of these items are over $500 (per item)."

Amount in Dispute: $698.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2018	E0730 -NU, A9150, E0215 -NU, L0627	$698.42	$674.79

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.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for durable medical equipment.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Is the insurance carrier's denial of the disputed services supported?
3. What rule is applicable to reimbursement?

Findings

1. The Austin carrier representative for American Casualty Co of Reading PA is Continental Casualty Co who acknowledged receipt of the copy of this medical fee dispute on October 5th, 2018. 28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. 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** [emphasis added]. 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.

   Review of the documentation finds that no response has been received on behalf of the insurance carrier from carrier rep to date. The division concludes that the insurance carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason, the division will base its decision on the information available.

2. The requestor is seeking $698.42 for durable medical equipment provided on April 14, 2018. The insurance carrier denied with denial code 197 – "Payment denied/reduce for absence of precertification/authorization.

   28 TAC §134.600 (p)(9) states in pertinent part,

   Non-emergency health care requiring preauthorization includes:

   (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

   Review of the submitted medical bill finds the following:

   - E0215 -NU, "Electric heat pad, moist" with a billed price of $99.68
   - E0730 -NU, "Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation" with a billed price of $73.75
   - A9150, "Nonprescription drugs" with a billed price of $25.00
   - L0627, "Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise" with a billed price of $499.99

   As the billed price for each of the items on the bill did not exceed $500, the disputed services will be reviewed per applicable fee guidelines.

3. The applicable fee guideline is found at 28 TAC §134.203 (d) which states in pertinent part,

   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; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

The maximum allowable reimbursement is calculated as follows:

- Code E0215-NU has an allowable of $79.74 in the April 2018 DMEPOS fee schedule. $79.74 x 125% = $99.68
- Code E0730-NU has an allowable of $59.00 in the April 2018 DMEPOS fee schedule. $59.00 x 125% = $73.75
- Code A9150 has no allowable listed in the DMEPOS fee schedule or Texas Medicaid fee schedule. 28 TAC §134.203 (f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)." 28 TAC §134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

  The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1 which are

  - how that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
  - documentation to demonstrate how it determined its usual and customary charges for the disputed services.
  - the comparison of charges to other carriers was not presented for review.
  - documentation of the amount of reimbursement received for these same or similar services was not presented for review.
  - nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

  Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended for A9150
- Code L0627 has an allowable in the April 2018 DMEPOS fee schedule of $401.09 x 125% = $501.36.

The total allowed amount is $674.79. This amount is recommended.

Conclusion

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 $674.79

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 $674.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		December 7, 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, 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 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. **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.