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

Respondent Name
Markel Insurance Co

MFDR Tracking Number
M4-19-1632-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
November 20, 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: $173.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the respondent's position that the durable medical equipment in dispute in this matter has an expected cumulative rental fee since the Claimant will require supplies for the equipment and could use the equipment long term. Therefore, preauthorization is required for the DME."

Response Submitted by: Downs Stanford P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2018	E0215 -NU, E0730 -NU	$173.43	$173.43

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:
    - C45 – Denied: Per carrier, pre-authorization not requested

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code C45 – "Denied: Per carrier, preauthorization not requested."

   28 Texas Administrative Code §134.600 (p)(9) states,

   > Non-emergency health care requiring preauthorization includes:
   >
   > > 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 found the submitted billed charges were for $99.68 for Code E0215 -NU and $73.75 -NU for Code E0730. The definition of the "NU" modifier found at www.cms.gov is ***This modifier is used when billing new, purchased items in the Inexpensive or Routinely Purchased (IRP) payment category.*** The respondent states, "…an expected cumulative rental fee…" as this is a purchased item the carrier's position is not supported. The services in dispute will be reviewed per applicable DWC fee guidelines.

2. The applicable DWC guideline found in 28 TAC 134.203 (d) (1) 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;

   Review of the 2018 DMEPOS fee schedule found the following:

   - The allowable for Code E0215 -NU, for date of service June 28, 2018 is $79.74 x 125% = $99.68
   - The allowable for Code E0730 -NU, for date of service June 28, 2018 is $59.99 x 125% = $73.75

   The total allowable is $173.43 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 $173.43.

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 $173.43, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

______________________	______________________	December 14, 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.