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
Crown Medical Billing

Respondent Name
Travelers Casualty & Surety Co

MFDR Tracking Number
M4-19-3357-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
March 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HCPS code E0676 does not have a fee schedule; the allowance should be based to charges for similar/comparable services."

Amount in Dispute: $6,234.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Carrier calculated reimbursement based on the reimbursement for similar durable medical equipment in accordance with the requirements of Rule 134.1(f) for fair and reasonable reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2018	E0676, E0218	$6,234.42	$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 reimbursement guidelines for durable medical equipment.
3. 28 Texas Administrative Code §134.1 defines fair and reasonable reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated

- 271 – The fee schedule does not include a value for the procedure code billed. An allowance has been made which is based on charges for similar/comparable services
- 947 – Upheld, no additional allowance has been recommended

Issues

1. Is the requestor's submitted amount supported?
2. Is the insurance carrier's denial supported?

Findings

1. The respondent states, "HCPS code E0676 does not have a fee schedule; the allowance should be based to charges for similar/comparable services. I am including 4 attachments from other insurances reimbursing the E0676.

   28 TAC §134.203 (d) states,

   > 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.

   Review of the applicable DMEPOS fee schedule finds no fee schedule amount for E0676 RR

   Review of the applicable Medicaid fee schedule finds no fee schedule amount for E0676 RR.

   The service in dispute will be reviewed pursuant to 28 TAC 134.203 (f) which states,

   > (f) 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) states,

   > 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.

   Review of the submitted documentation finds:

   - The requestor does not discuss or demonstrate how reimbursement of $6,000.00 for code E0676 -RR is a fair and reasonable reimbursement
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute
   - The requestor did submit documentation that E0676 -RR had received similar reimbursement
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments

The Division concludes that the submitted documentation does not meet the required criteria of Labor Code §413.011 and all of the requirements of 28 TAC §134.1 (f). The requestor's position is not supported. No additional reimbursement is recommended.

2. The requestor is seeking reimbursement for Code E0218 – "Fluid circulating cold pad with pump, any type." The insurance carrier denied the service as, 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The respondent states, "…code E0218, the fluid circulating pad performs similar functions to the pneumatic compression provided by CPT codes E0650 and E0666. …therefore, was global to the reimbursement issued for the primary device."

Review of the description of Code E0218 is, "fluid circulating cold pad with pump." The description of Code E0650 is "Pneumatic compressor." As one circulates cold fluid and the other allows air to be pumped into a sleeve that applies compression, the respondent's position is not supported.

The reimbursement is based on provisions of §134.203 (d) shown above.

Review of the applicable DMEPOS fee schedule finds no fee schedule amount for E0218 RR

Review of the applicable Medicaid fee schedule finds no fee schedule amount for E0218 RR.

The service in dispute will be reviewed pursuant to 28 TAC §134.203 (f) shown above.

- The requestor does not discuss or demonstrate how reimbursement of $1,299.00 for code E0218 -RR is a fair and reasonable reimbursement
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute
- The requestor did submit documentation that E0218 -RR had received similar reimbursement
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments

The Division concludes that the submitted documentation does not meet the required criteria of Labor Code §413.011 and all of the requirements of 28 TAC §134.1 (f). No additional reimbursement 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

______________________	____	April 10, 2019
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.