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
Protective Insurance Co

MFDR Tracking Number
M4-19-3567-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 22, 2019

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: $321.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Respondent's position that DWC Rule 134.600 (p) (12) requires all treatment that exceed or are not addressed by the commissioner's adopted treatment guidelines require preauthorization. The TENS unit is not recommended in the Official Disability Guidelines (ODGs) for the Claimant's condition, and nor is the lumbar support brace. Therefore, because they are not recommended by the ODGs, preauthorization is required."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2018	E0215 -NU, E0730 -NU, L0642	$574.74	$572.75

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 professional medical

services.

3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.
4. 28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - ODG – Services exceed ODG guidelines;preauth is required

Issues

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

Findings

1. The requestor is seeking reimbursement of $573.74 for durable medical equipment provided on October 11, 2018.

   The respondent submitted as their position statement, "The TENS unit is not recommended in the Official Disability Guidelines (ODGs) for the Claimant's condition, and nor is the lumbar support brace. Therefore, because they are not recommended by the ODGs, preauthorization is required."

   28 Texas Administrative Code §137.100 (e) states,

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   28 TAC Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

   Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

   No documentation found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required.

   The carrier did not or perform requirements of retrospective review, therefore, services in dispute will be reviewed based on applicable fee guideline.

2. 28 Texas Administrative Code §134.203 (d) 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 finds the following:

   Code E0730: Tens unit - Allowable $59.00. Code L0642: Lumbar Orthosis - Allowable $401.09

The MAR is calculated as follows:

Code	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement	Allowed amount
E0730	$73.75	$59.00	$59.00 x 125% = $73.75	$73.75
E0215	$499.99	$401.09	$401.09 x 125% = $501.36**	$499.99

TAC 134.203 h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be **the least of the:

(1) MAR amount;

(2) health care provider's **usual and customary charge**, unless directed by Division rule to bill a specific amount;

3. The total allowable amount is $572.75. This amount is due to the requestor.

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 $572.75.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $572.75, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		May 2, 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 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.