TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Duramed

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-20-1644-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 4, 2020

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 $500.00"

Amount in Dispute: $68.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Duramed Inc was required by division rule to obtain preauthorization for HCPCS Code E0730 (RR) since the treatment and/or services proposed exceed or are not addressed by the commissioner's adopted treatment guidelines for the diagnosis code(s) billed. Moreover, the requestor has failed to provide sufficient evidence to substantiate that ODG criteria has been met for the use of a TENS unit for treatment of the diagnoses billed."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2019	E0730-RR	$68.69	$68.69

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 guidelines for durable medical equipment.
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. Is the insurance carrier's reason for reduction of payment supported?
2. What rule apply to reimbursement of durable medical equipment?

Findings

1. The requestor is seeking additional reimbursement $68.69 for reimbursement of Code E0730 in July 2019. The respondent denied based on ODG guidelines being exceeded so the services required pre-authorization.

   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 §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 and 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

   Insufficient evidence was 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.

   Based on the above, the insurance carrier's denial is not supported. The disputed service will be reviewed per applicable fee guideline.

2. 28 TAC §134.203 (d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.

   The Medicare allowable for Code E0730-RR for Texas is $54.95. This amount multiplied by 125% equals a MAR of $68.69. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $68.69.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $68.89, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 31, 2020 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 DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.