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
Employers Preferred Insurance Company

MFDR Tracking Number
M4-21-0486-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
November 28, 2020

Response Submitted by:
Employers

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."

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Review of the claim reveals that this provider independently dispensed this Tens unit without prior authorization from the insurer. A formal request for prior authorization was not received until 11/03/20. Utilization review company non-certified 1 Tens unit on 11/06/20. Therefore, the provider runs the risk of dispensing equipment without a prior authorization and thus, the insurer should not be liable for payment."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 8, 2020	E0730-RR	$69.79	$69.79

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for durable medical equipment.
3. 28 TAC §134.600 sets out the requirements of prior authorization.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
    - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
    - P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES
    - 6532 – ABSENCE OF, OR EXCEEDS, PRE-CERTIFICATION/AUTHORIZATION

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 seeks reimbursement in the amount of $69.79 for HCPCS Code E0730 rendered on September 8, 2020. The respondent denied based on the services required pre-authorization.

   28 TAC §134.600 (p)(9) states, "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)…"

   Based on the documentation submitted, the DWC finds that the insurance carrier's denial is not supported. The requestor is therefore entitled to reimbursement for the disputed service.

2. HCPCS Code E0730 is subject to reimbursement pursuant to 28 TAC §134.203 (b), which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifier."

   The applicable Medicare payment policy is found at, www.cms.hhs.gov, Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), "In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months." Per the Medicare policy, the rental modifier is appropriate.

   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;

   The Medicare allowable for Code E0730-RR in Texas is $55.83. This amount multiplied by 125% equals a MAR of $69.79. 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 $69.79.

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 $69.79, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 9, 2020
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 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.