TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ANTHONY JAMES ESQUIBEL

Respondent Name
XL SPECIALTY INSURANCE COMPANY

MFDR Tracking Number
M4-22-0001-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 1, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 22, 2021	E0730-RR and E0215-NU	$285.04	$249.31
	Total	$285.04	$249.31

Requestor's Position

"All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid. Therefore, this claim should be PAID IN FULL to prevent IRO (independent Review Organization) and MFDR (Medical fee Dispute Resolution)."

Amount in Dispute: $285.04

Respondent's Position

"The Provider contends they are entitled to reimbursement for the disputed services because they did not require preauthorization. Rule 134.600(p)(12) requires preauthorization for all treatments and services that exceed the Division's adopted treatment guidelines. As documented by the attached ODG excerpt, the use of TENS units is not recommended for wrist injuries such as the one sustained by the Claimant. As the treatment is not recommended by ODG, it exceeds the recommended treatment and required preauthorization. Since preauthorization was not obtained prior to the Provider filling the DME prescription, no reimbursement is allowed for these services."

Response Submitted by: Constitution State Services

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

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 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.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 242 – Services not provided by network/primary care providers.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 309 – The charge for this procedure exceeds the fee schedule allowance
- 5421 –This device is being reimbursed according to fee schedule UCR allowance for HCPCS procedure code E0730, TENS four leads, which is the therapeutic equivalent.
- 5682 – Pre-authorization was not obtained prior to the service/procedure being rendered

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor is seeking additional reimbursement $285.04 for reimbursement of E0730-RR and E0215-NU on February 22, 2021. 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 Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

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.

Review of the 2021 DMEPOS Fee Schedule finds the following:

The Medicare allowable for Code E0730-RR for Texas is $146.23. This amount multiplied by 125% equals a MAR of $182.79. This amount is recommended.

The Medicare allowable for Code E0215-NU for Texas is $82.46. This amount multiplied by 125% equals a MAR of $103.08. This amount is recommended.

The requestor is therefore entitled to a total reimbursement amount of $249.31.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $249.31 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $249.31, plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 5, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.