TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-23-1389-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 14, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2022	L1833	$499.99	$499.99
December 14, 2022	E0730	$29.99	$19.22
December 14, 2022	A4556	$29.72	$0.00
	Total	$559.70	$519.21

Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states, "Please note item submitted for payment falls within the following guidelines for payment and should be processed for payment immediately, as pre-authorization is not required for this item(s) & it is medically necessary and reasonable, as it was prescribed by the treating doctor…"

Amount in Dispute: $559.70

Respondent's Position

"Our bill audit company has determined no further payment is due."

Response submitted by: Gallagher Bassett

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 §133.307 sets out guidelines for medical fee dispute resolution.

2. 28 Texas Administrative Code §124.2 sets out the requirements of plain language notification.

3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for durable medical equipment.

Denial Reasons

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

For codes E0730 and A4556

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 - Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 105 – Payment adjusted because rent/purchase guidelines were not met
- P12 – Workers compensation jurisdictional fee schedule adjustment

For code L1833

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 18 – Exact duplicate claim/service
- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
- 219 – Based on extent of injury

Issues

1. Did the respondent meet requirements of plain language notice?

2. What is the rule applicable to reimbursement?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of the following durable medical equipment and orthotic provided in November and December 2022. The insurance carrier originally denied the (E0730) and (A4566) as rent/purchase guidelines not met. The orthotic (L1833) was denied based on extent of injury, duplicate bill and wrong carrier received bill.

   DWC Rule 28 TAC §133.307(d)(2)(H) requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements).

   DWC Rule 28 TAC §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Review of the submitted information finds no copies, as required by Rule §133.307(d)(2)(H), of any PLN-11 or PLN 1 notices issued in accordance with Rule §124.2. The insurance carrier's denial reason is therefore not supported. Furthermore, because the respondent failed to meet the requirements of Rule §133.307(d)(2)(H) regarding notice of issues of extent of injury, the respondent has waived the right to raise such issues during dispute resolution. Consequently, the division concludes there are no outstanding issues of compensability, extent, or liability for the injury. The disputed services are therefore reviewed pursuant to the applicable rules and guidelines for Code L1833.

   The carrier denied codes E0730 – Tens unit as rent/purchase requirements not met and A4556 (electrodes) as packaged,

   The rule applicable to durable medical equipment coding is DWC Rule 134.203 (b) which states in pertinent part, "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; modifiers."

Review of the applicable Medicare payment policy at www.cms.gov, found,

"During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for items such as electrodes, lead wires, and batteries."

The insurance carrier's denial for packaging for code A4556 (electrodes) is upheld. No separate reimbursement is recommended.

The applicable Medicare payment policy regarding code E0730 (Tens) is found at https://www.cgsmedicare.com/jc/pubs/pdf/chpt5.pdf and states, *Transcutaneous Electrical Nerve Stimulator (TENS), CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, §30.1.2*

TENS devices constitute an exception to the IRP category. Up to two months rental is allowed prior to the purchase of a TENS in order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular beneficiary. The purchase price is determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

and

CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, §30.5 Rental Fee Schedule, For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10 percent of the average of allowed purchase prices on assigned claims.

The insurance carrier's denial of the tens unit based on rent/purchase guidelines is not supported as review of the medical bill found the requestor submitted the claim as, E0730-RR. The rental of the Tens unit code E0730 will be reviewed per fee guideline and applicable Medicare payment policy shown above.

2. DWC Rule 134.203(d) 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;

   The purchase price for Code E0730 is $153.82. One-tenth of the purchase price is $15.38. This amount multiplied by 125% equals $19.22.

   The allowable for code L1833 is $472.65. This amount multiplied 125% equals a MAR of $590.81. The requestor is seeking $499.99. This amount is recommended.

3. The total allowed amount for the services in dispute is $519.21. This amount is recommended.

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 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Old Republic Insurance Co must remit to Peak Integrated Healthcare $519.21 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 31,2023 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.