Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-23-1994-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2023	E0730-NU	$167.38	$167.38
January 11, 2023	A4595	$73.68	$23.02
January 11, 2023	E0731-NU	$167.93	$167.93
January 11, 2023	E1399-NU	$34.99	$0.00
	Total	$438.98	$358.33

Requestor's Position

The requestor did not submit a position statement but rather submitted a copy of their reconsideration that states, "The Texas Administrative Code Rule 134.600(P)(12) – any single item durable medical equipment (DME) under $500 does not need pre-authorization."

Amount in Dispute: $438.98

Respondent's Position

"Texas Mutual received the bill charges (DWC-66) from Peak Integrated Healthcare. Audit staff reviewed the bill and determined that the Official Disability Guidelines (ODG) does not recommend the use of a TENS unit for forearm, wrist and/or hand injures. Texas Mutual reviewed the claim and found no documentation showing a medical emergency involving the prescription

DME in dispute or that preauthorization was sought due to the non-recommended use per treatment guidelines."

Response submitted by: Texas Mutual

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 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. 28 Texas Administrative Code §134.1 defines fair and reasonable.

Denial Reasons

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

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 197 – Precertification/authorization/notification absent
- 762 – Treatment/service in excess ODG/DWC treatment guidelines in accordance with TAC Rule 134,502, 503 & 134.600(p)(12)
- 785 – Service rendered is integral to service requiring preauthorization or DOS exceeds preauth, additional preauth or extension not on record

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 durable medical equipment provided in January 2023.

   The respondent denied the disputed service for lack of prior authorization as ODG guidelines exceeded. DWC Rule 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.

DWC Rule 28 Texas Administrative Code 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 service in dispute will be reviewed based on applicable fee guidelines.

2. DWC Rule 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 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 applicable DMEPOS fee schedule found the following allowable.

   - E0730 – 167.38 x 125% = Maximum allowable reimbursement (MAR) = $209.23. The requestor is seeking $167.38. This amount is recommended.

     A4595 – $18.42 X 125% = (MAR) of $23.02

   - E0731 - $162.93 X 125% = $203.66. The requestor is seeking $167.93. This amount is recommended.

   - E1399 – No published fee guideline. DWC Rule 28 TAC 134.1 states, (e)(3) and (f)(1)(2)(3) state in pertinent parts, medical reimbursement in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

     (f) Fair and reasonable reimbursement shall: be consistent with the criteria of Labor Code §413.011; ensure that similar procedures provided in similar circumstances receive similar reimbursement; and be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

     Insufficient evidence found to support the requirements of fair and reasonable. No additional payment recommended.

3. The requested amount for Code E0730 and E0731 is $335.31. The MAR for Code A4595 is $23.02 for a total recommended amount of $358.33.

<u>Conclusion</u>

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 not entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual must remit to Peak Integrated Healthcare $358.33 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	May 3, 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.