



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

PEAK INTEGRATED HEALTHCARE

**Respondent Name**

STARR INDEMNITY & LIABILITY COMPANY

**MFDR Tracking Number**

M4-23-2165-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 3, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 26, 2023	E0730, A4595, E0215 and E1399	\$370.27	\$167.38
<b>Total</b>		\$370.27	\$167.38

### Requestor's Position

"The Texas Administrative Code Rule 134.600 – any SINGLE durable medical equipment/DME under \$500 – does not need pre-authorization. This is not a cumulative rental."

**Amount in Dispute:** \$370.27

### Respondent's Position

"...while the provider claims that rule 134.600 does not require preauthorization of durable medical equipment under \$500, there is another rule that may require preauthorization. That rule is 137.100 which provides that if the services are outside of or beyond the ODG, preauthorization is required."

**Response Submitted by:** Flahive, Ogden & Latson

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.
4. [28 TAC §134.600](#) sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
5. [28 TAC §134.1](#) effective March 1, 2008, sets out general provisions regarding medical reimbursement.
6. [28 TAC §137.100](#) sets out provision of the treatment guidelines.

### Denial Reasons

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

- 5721 – To avoid duplicate bill denial for all reconsiderations/adjustments/additional payment requests submit a copy of this EOR
- ZK10 – A payment or denial has already been recommended for this service.
- 90438 & 197 – Payment denied/reduced for absence of precertification/authorization.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

### Issues

1. What is the description of HCPCS codes E0730, A4595, E0215 and E1399?
2. Is the insurance carrier's denial reason supported?
3. Has the requestor submitted sufficient documentation to support the reimbursement for HCPCS codes E1399 and A4595?
4. Is the requestor entitled to reimbursement for HCPCS code E0730-NU?
5. Has the requestor established that reimbursement is due?

## Findings

1. The requestor seeks reimbursement for HCPCS codes E1399, E0730-NU, A4595, and E0215-NU described below.

28 TAC §134.203(a)(5) states, "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

The description for the disputed HCPCSs codes are as follows:

- E1399 - Durable medical equipment, miscellaneous
  - E0730-NU - Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
  - A4595 - Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)
  - E0215-NU - Electric heat pad, moist
  - Modifier NU - This modifier is used when billing new, purchased items
2. The requestor seeks reimbursement for HCPCS Codes E0730-NU, A4595, E0215-NU and E1399-NU rendered on January 26, 2023.

The insurance carrier denied the disputed charge with denial reason codes "CAC-197 – Precertification/authorization/notification absent."

28 TAC §134.600(p) (12) states in pertinent part "(p) 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)."

The disputed DME charges are not in excess of \$500 billed charge per item, as a result, the division refers to 28 TAC §137.100.

28 TAC §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."

Review of the ODG guidelines for HCPCS code E0215 does not recommend the use of the Electric Head Pad, as a result preauthorization was required, per rule 137.100 and not obtained. The requestor is therefore not entitled to reimbursement for HCPCS code E0215.

A review of 28 TAC §134.600 and §137.100 does not support that preauthorization is required for HCPCS codes E1399, A4595, and E0730-NU. As a result, the codes are reviewed pursuant to 28 TAC §134.203.

3. The requestor seeks reimbursement for HCPCS codes E1399 and A4595. Review of the applicable DMEPOS fee schedule and the Texas Medicaid fee schedule, finds no fee schedule amount for E1399 and A4595.

HCPCS codes E1399 and A4595 are reviewed pursuant to 28 TAC §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 TAC §134.1 states, Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) 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.

For the reasons indicated above, 28 TAC §133.307(c)(2)(O) applies and, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

A review of the submitted documentation finds:

- The requestor fails to explain or provide evidence as to why the reimbursement of \$35.00 for code E1399 -NU and the payment of \$73.68 for code A4595 is a fair and reasonable reimbursement.
- The reimbursement amount asked by the requestor is not supported by documentation demonstrating that it is a fair and reasonable rate of reimbursement.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

The DWC finds that the requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1. As a result, the division concludes that the requestor failed to support its request for reimbursement for HCPCS codes E1399 and A4595. For that reason, no reimbursement can be recommended.

4. The requestor seeks reimbursement for HCPCS code E0730-NU. HCPCS code is subject to the requirements of 28 TAC §134.203(d) which 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; or
- (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the submitted documentation finds that the requestor seeks reimbursement in the amount of \$167.38, for HCPCS code E0730-NU.

- The DMEPOS fee schedule is \$167.38 multiplied by 125% equals a MAR amount of \$209.23.
- The insurance carrier paid \$0.00.
- Since the requestor seeks \$167.38, this amount is recommended.

The DWC finds that the requestor is entitled reimbursement for the HCPCS code E0730. Review of the submitted documentation finds that the requestor is entitled to reimbursement for disputed HCPCS Code E0730-NU rendered on January 26, 2023. As a result, this amount is recommended.

5. The DWC determines that for the reasons indicated above, the requestor is entitled to reimbursement of \$167.38. 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.

The DWC finds the requester has established that reimbursement of \$167.38 is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, the DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor the amount of \$167.38, plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TC §134.120.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 17, 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).