Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Peak Integrated Healthcare

Respondent Name
United Wisconsin Insurance Co

MFDR Tracking Number
M4-24-0476-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
October 27, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 8, 2023	E0217	$422.62	$0.00
	Total	$422.62	$0.00

Requestor's Position

"Per utilization review APPROVAL (attached), carrier is liable for the amount of $514.50. The carrier paid $91.88. The balance is $422.62.

Amount in Dispute: $422.62

Respondent's Position

"Requestor seeks additional payment for rental of a water circulating heat pad with pump for period of 7 days. UWIC paid the fee schedule amount of $91.88 and so indicated on the Explanation of Benefits dated 09/29/23 with reduction code P12 (Payment has been determined using the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule). Requestor incorrectly asserts that UWIC agreed to pay its *billed* charges of $73.50 per day. Preauthorization of the DME pursuant to Rule 134.600(p)(9) is not an agreement to pay any specific amount. Neither UWIC nor its Utilization Review Agent ever agreed to pay Requestor at the rate of $73.50 per day or any amount other than the fee schedule amount."

Response Submitted by: Stone Loughlin Swanson

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) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets the reimbursement guidelines for the disputed service.

Denial Reasons

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

- P12 – Payment has been determined using the Durable Medical Equipment, Prosthetics, and Supplies (DMEPOS) fee schedule.
- 131 – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined with the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider's charge was granted as allowance up to the MUE value.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's denial for Medically Unlike Edits (MUEs) supported?

2. What rule is applicable to reimbursement?

3. Is the requestor due additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of Code E0217 in the amount of $422.62 for date of service August 8, 2023. The insurance carrier reduced the payment based on Medicare Medically Unlikely Edits (MUEs).

   The DWC finds the reports also refer to a Medicare payment policy regarding Medically Unlikely Edit (MUE). MUE's were implemented by Medicare in 2007. MUE's set a maximum

number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although the DWC adopts Medicare payment policies by reference in applicable Rule §134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code §413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule §134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. The DWC concludes that Labor Code §413.014 and 28 TAC §134.600 take precedence over Medicare MUE's; therefore, the respondent's denial reasons are not supported.

2. DWC Rule 134.203 (b)(1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing…"
   The Medicare payment policy for DME is found at www.cms.gov, Medicare Claims Processing Manual, Chapter 20, Section 30.1 – Inexpensive or Other Routinely Purchase DME.

   > *For this type of equipment, A/B MACs (A), (B), or (HHE), and DME MACs pay for rental or lump-sum purchases.*

   Review of the submitted medical bill indicates the "RR" modifier for rental however, the units indicated is "7". Review of the applicable Medicare payment policy does not indicate this item is paid on a daily rate. The applicable fee guideline calculation is shown below.

   DWC Rule TAC §134.203 (d)(1) states in pertinent parts, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E. J, K, and L shall be determined as 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   The fee schedule amount for E0217-RR for Texas on the applicable date of service is $73.50. This amount multiplied by 125% = $91.88.

   Additionally, the submitted medical bill indicates place of service "11 – Physician's office" in box 24B. The Medicare Claims Processing Manual, Chapter Four, Chapter 20, Section 10.1.1 (d) at www.cms.gov defines as "*appropriate for use in the home*" and Section 10.2 Conditions states, "*Reimbursement may be made for expenses incurred by a patient for the rental or purchase of durable medical equipment (DME) for use in his/her home*."

3. The total allowable for the service in dispute is $91.88. The insurance carrier paid $91.88. No additional payment is due.

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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 27, 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.