Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JOINT ACTIVE SYSTEMS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-12-2338-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our device is a bidirectional static progressive stretch wrist device used to help increase range of motion. It is a monthly rental item. It is worn an average of 3 times a day in 30-40 minute sessions for 1-4 months... we request that the denial(s) be reversed and payment for the claim(s) be made."

Amount in Dispute: $138.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position identified through its Explanation of Benefits issued to the requestor for disputed date 9/14/11. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2011	E1806	$138.87	$138.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

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 Medical Fee Guideline for Professional Services.
3. 28 Texas Administrative Code §134.600 sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. 28 Texas Administrative Code §137.100 sets out the Divisions treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC 19 – Duplicate claim/service.
   - CAC 197 – Precertification/authorization/notification absent.
   - 762 – Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
   - 878 – Appeal (Request for reconsideration) previously processed. Refer to rule 133.250(H).
   - 891 – No additional payment after reconsideration.
   - CAC 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. What is the definition of HCPCS Code E1806?
3. Does HCPCS code E1806 require preauthorization?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Illinois to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §134.203(b)(1) states, "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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for HCPCS Code E1806 defined by AMA CPT Code Book as, "Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories."
3. 28 Texas Administrative Code §134.600(p)(12) states, "Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   The disputed HCPCS Code E1806 is not identified in 28 Texas Administrative Code §134.600, as a result HCPCS Code E1806 is subject to the provisions of 28 Texas Administrative Code §137.100.

   Per 28 Texas Administrative Code §137.100 "(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless: (1) the treatment(s) or service(s) were provided in a medical emergency; or (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title."

   Per 28 Texas Administrative Code §137.100 "(e) 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."

   Per 28 Texas Administrative Code §137.100 "(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

   Review of the submitted documentation finds that the Static progressive stretch wrist devise is a recommended treatment per the Official Disability Guidelines, as a result preauthorization was not required and the requestor is entitled to reimbursement for the disputed HCPCS Code E1806.
4. 28 Texas Administrative Code §134.203(c) (d) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications... (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 DMEPOS fee schedule reimbursement for HCPCS Code E1806 is $113.77 x 125% = $142.21. The requestor seeks $138.87, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $138.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $138.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 23, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.