



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME Inc

Respondent Name

American Hallmark Insurance Company of Texas

MFDR Tracking Number

M4-17-0367-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

October 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 04/28/2016 they issued a partial payment for codes E1399,E1399 in the amount of \$41.65 they denied code E0190. Per EOB it stated that payment adjusted for absence of precert/preauth, this was denied in a billing error. Per Subchapter G. Prospective and Concurrent review of health care. 134.600. Pre-authorization, Concurrent Review, and Voluntary Certification of Health Care. All durable medial [sic] equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental.) We did not need authorization for this item per the rule 134.600."

Amount in Dispute: \$255.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Universal DME LLC was required by division rule to obtain preauthorization for HCPCS Code E0190 since the treatment and/or services proposed exceed or are not addressed by the commissioner's adopted treatment guidelines for the diagnosis code(s) billed. Moreover, the requestor has failed to provide sufficient evidence to substantiate that ODG criteria have been met for the use of a Positioning cushion/pillow/wedge for treatment of the diagnosis billed. As such, per disability management rules under §137.100 the insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines.

CorVel maintains the requestor, Universal DME LLC is not entitled to additional reimbursement for unlisted HCPCS Code E1399 (Exercise Pulley) and E1399 (Exercise Pedal) based on fair and reasonable reimbursement."

Response Submitted by: Corvel Healthcare Corporation

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 15, 2016, E0190 - NU, E1399 - NU, E1399 - NU, Total \$255.35, \$59.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §137.100 details concepts of disability management.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Payment adjusted for absence of precert/preauth
 - 234 – This procedure is not paid separately
 - NU – New Equipment
 - P5 – Based on payor reasonable/customary fees
 - W3 – Appeal/reconsideration
 - ORC – See additional information
 - R38 – Included in another billed procedure
 - 193 – Original payment decision maintained
 - B13 – Payment for services may have been previously paid
 - ODG – Services exceed ODG guidelines;preauth is required
 - P14 – Payment is included in another svc/procdre occurring on same day

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The denied service in dispute is for code E0190 – "Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories." The insurance carrier denied disputed services with claim adjustment reason code ODG – "Services ODG guidelines;preauth is required" and 197 – "Payment adjusted for absence of precert/preauth."

28 Texas Administrative Code §137.100 (e) and (g) state,

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.

The Insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

Review of the submitted documentation finds insufficient evidence to support a retrospective review compliant with Rule 137.100(e) was performed. The carrier's denial is not supported. The service E0910 will be reviewed per applicable rules and fee guidelines.

2. The services that remain in dispute are E0190 and E1399. 28 Texas Administrative Code §134.203(d) 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.

For code E0190 no allowable was found in the DMEPOS fee schedule. Review of the Texas Medicaid fee schedule found an allowable of \$47.99. Because of the above the maximum allowable reimbursement is calculated at ($\$47.99 \times 125\% = \59.99). This amount is recommended.

The carrier paid \$21.66 for E1399 and \$19.99 for second E1399 code. The requestor is seeking an additional payment in the amount of \$156.35.

For code E1399 no allowable was found in the DMEPOS fee schedule. Review of the Texas Medicaid fee schedule also found no allowable. Therefore Rule 134.203(d)(3) applies.

28 Texas Administrative Code §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 Texas Administrative Code §134.1(f) 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.

28 Texas Administrative Code §133.307(c)(2)(O), states in pertinent part,

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.

Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how an additional payment of \$79.01 for E1399 – P9634, NU and \$77.34 for E1399 – P9633, NU is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- 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 resources commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The total allowable for the services in dispute is \$59.99. 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 \$59.99.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$59.99, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 3, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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