TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Healing Hands Family Chiropractic

Respondent Name

Hartford Casualty Insurance Co

MFDR Tracking Number

M4-26-2650-01

Insurance Carrier's Austin Representative

BOX 47 Burns Anderson Jury Brenner & Donovan

DWC Date Received

May 21, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 26, 2026	E0730 RR	$239.50	$0.00
	Total	$239.50	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Reconsideration" that states, "The rental billed for this claim represents a 30-day period (30 units) only. This does not exceed the stated two-month rental limitation. In fact, this is the patient's first and only TENS unit rental, as the patient had not previously been issued a TENS unit prior to this date of service."

Amount In Dispute: $239.50

Respondent's Position

"After further review of the documentation submitted with this dispute, there is no additional amount warranted."

Response Submitted By: The Hartford

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- 119 – Benefit maximum for this time period or occurrence has been reached.
- 163 – The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the insurance carrier's reduction supported?

3. What rule is applicable to reimbursement of the disputed service?

4. Has DWC determined whether additional reimbursement is due?

Findings

1. The requester submitted to Medical Fee Dispute Resolution (MFDR) for additional reimbursement of code E0730 RR (tens rental) in the amount of $239.50 for date of service February 26, 2026. The insurance carrier reduced the paid amount based on the DME rental timeframe. DWC will review the applicable DWC rules and fee guidelines to determine if additional reimbursement is due.

2. The insurance carrier denied the amount billed based on DME rental timeframe. 28 TAC Section 134.203(b)(1) states, For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation participants shall apply the following: Medicare payment policies, including is coding; billing; correct coding initiatives (CCI) edits; modifiers…

   28 TAC Section 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 payment amount will be reviewed per the applicable DWC rules discussed below.

3. The applicable Medicare payment policy is found at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c20.pdf and states, **30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13)** In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, MACs pay **10 percent of the purchase price of the item for each of 2 months**.

   Review of the applicable pricing for E0730 is found in 28 TAC Section 134.203(d)(1), The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: 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 is located at the following web site, https://www4.palmettogba.com/pdac_dmecs/initFeeScheduleLookup.do

   - The zip code for the rendered service is 76244. This is a non-rural zip code.
   - The purchase price of the Tens unit for February 26, 2026 is $70.37. This amount is paid at 10% of the purchase price or $70.37 x 10% = $7.037
   - $7.037 x 125% = $8.80

   The billed number of units on the submitted medical bill indicates, "30" however, as seen above this is a MONTHLY rental and the applicable Medicare payment policies allow for a monthly rental not a daily rental.

4. Based on the information available at the time of this review, the applicable DWC fee guidelines indicates a MAR of $8.80 for the one month rental of the Tens unit in February of 2026. The insurance carrier paid $17.60. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 17, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.