Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THERAPY SUPPLY HOUSE
6725 STELLA LINK ROAD
HOUSTON TX 77005

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-08-2679-01

MFDR Received Date
DECEMBER 27, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Total amount paid is below vendors cost amount."

Amount in Dispute: $9,344.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. 1. DWC Rule 134.202 states in part, '(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.' 2. Reimbursement is based on Palmetto GBA, DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, Supplies) fee schedule with the exception of code E1340 which is not listed in DMEPOS. As such, Texas Mutual's reimbursement methodology for code E1340 is based on fair and reasonable standards. Given the above, Texas Mutual believes no further payment is due and respectfully asks that the requestor withdraw its request for dispute resolution."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 29, 2007	DME – Repair of wheel chair HCPCS Codes: E1028, E1340, E2377, E2620, E2321, E2381, E1010, E2363	$9,344.99	$1,284.76

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 §134.202 is the Medical Fee Guideline.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/12/2007:
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 18 – Duplicate claim/service.
   - 878 – Duplicate appeal.
   - 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor bill the repair of the wheel chair in accordance with 28 Texas Administrative Code 134.202(c)(2)(A-C)?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(c)(2)(A-C) Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L are paid 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule. If the code has not published Medicare rate, 125% of the published Texas Medicaid Fee Schedule for durable medical equipment, Report J or if neither of the above apply, then as calculated according to paragraph 6 of this subsection, which states that for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized pubished relative value studies, published commission medical dispute decisions, and values assigned for service involving similar work and resources commitments.
   - E1028 – Wheelchair accessory, manual swigaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory. Per 28 Texas Administrative Code 134.202(c)(2)(A) reimbursement total is $258.18, the insurance carrier paid $258.18; therefore, additional reimbursement is not recommended.
   - E1340 – Repair of nonroutine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. This code has no published Medicare or Texas Medicaud rate; therefore, per 28 Texas Administrative Code 134.202(c)(6), the insurance carrier paid a total of $369.80; the health care provider has not submitted any documentation, other than their itemized statement to support additional reimbursement. Therefore, additional reimbursement is not recommended.
   - E2377 – Power wheelchair assessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue. Per 28 Texas Administrative Code 134.202(c)(2)(A), reimbursement total is $607.14, the insurance carrier paid $607.14; therefore, additional reimbursement no recommended.
   - E2620 – Positioning wehhelchair back cushion, planar back with lateral supports, width less than 22 in., any height, including any type mounting. Per 28 Texas Administrative Code 134.202(c)(2)(A), reimbursement total is $684.63, the insurance carrier paid $684.43. Therefore, additional reimbursement is not recommended.
   - E2321 – Power wheelchair assessor, hand control interface, remote joystick, nonproportional, including all related electronics, medchanical stop switch, and fixed mounting hardware. Per 28 Texas Administrative Code 134.202(c)(2)(A) reimbursement total is $1,986.38, the insurance carrier paid $1,986.38. Therefore, additional reimbursement is not recommended.
   - E2381 – Power wheelchair accessory, pneumatic drive shee tire, any size, replacement only, each. Per 28 Texas Administrative Code 134.202(c)(2)(A), reimbursement total is $95.23, the insurance carrier paid $190.45. Therefore, additional reimbursement is not recommended.
   - E1010 – Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair. Per 28 Texas Administrative Code 134.202(c)(2)(A) reimbursement total is $2,497.50; the insurance carrier paid $1,429.74. Therefore, additional reimbursement of $1,069.76 is due.
   - E2363 – Power wheelchair accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat). Per 28 Texas Administrative Code134.202(c)(2)(A) reimbursement total is $843.81; the health care provider billed $843.75 and the insurance carrier paid $465.00; therefore, additional reimbursement of $215.00 is due.
2. Review of the submitted documentation finds that the requestor is due reimbursement.

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 $1,284.76.

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 $1,284.76 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 5, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN 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.