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
MedMe Services Corporation

Respondent Name
XL Specialty Insurance Co

MFDR Tracking Number
M4-11-3132-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the Medicare Fee Schedule allows $469.56 to be paid on this item. It was paid below this amount and appealed but denied additional monies.."

Amount in Dispute: $71.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Acknowledgement of medical fee dispute received however, no written response submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2010	E0745	$71.16	$0.00

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 §134.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 5 – The procedure code/bill type is inconsistent with the place of service
   - B13 – Previously paid
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Did the requestor submit the bill with correct code and modifiers?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 states, in pertinent 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 and "(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) code. Additionally, commission specific modifiers are identified in paragraph (9) of this subsection." Review of the submitted documentation finds HCPCS code E0745 – NU was submitted on claim line. Per DMEPOS Fee Schedule the service in dispute is classified as "Capped Rental" as such purchase in the first month is not allowed but rather per CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, Subchapter 30.5 "For these items of DME, contractors pay the fee schedule amounts on a monthly rental basis not to exceed a period of continuous use of 15 months." Therefore, the division finds purchase in the first month (modifier NU) cannot be allowed.

2. 28 Texas Administrative Code §134.203 (c)(A) states in pertinent part, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: … (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; Therefore the total MAR is calculated as follows DMEPOS fee schedule $93.99 x 125% = $117.48. The carrier paid $398.40. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		June , 2014
Signature	Medical Fee Dispute Resolution Officer	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.