**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 and Address**

MEDME SERVICES CORPORATION
PO BOX 920173
EL PASO, TX 79902

**Respondent Name**
Old Republic General Insurance

**Carrier's Austin Representative Box**
Box Number 44

**MFDR Tracking Number**
M4-11-4418-01

**MFDR Date Received**
August 1, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The Medicare allowable for this item is $469.56 for the state of Texas. The amount owing is warranted and payable as billed."

**Amount in Dispute:** $71.16

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received, however no response submitted.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 3, 2011 | E0745 NU | $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 §133.203 sets out the reimbursement guidelines for professional medical services.
3. 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. Payment for this claim/service may have been provided in a previous payment.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

**Issues**

1. Were the services in dispute billed in accordance to division guidelines?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.203 states, in pertinent part, "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; …and other payment policies in effect on the date a service is provided…" The medical bill for the service in dispute included HCPCS code E0745 NU. This code is classified as "Capped Rental Items" based on HCPCS code fee schedule category. Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 20, Section 30.5 states in pertinent part, "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." The purchase of this DME item in the first month does not comply with Medicare payment policies in effect at the time of service.
2. 28 Texas Administrative Code §134.203(d) (1) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2011, the maximum allowable reimbursement = (DMEPOS Fee Schedule / 125%) or DMEPOS allowable rental $93.90 x 125 = $117.38. The total allowable for the disputed services is $117.38. The carrier paid $398.40. No additional reimbursement 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**

| Signature | Medical Fee Dispute Resolution Officer | January , 2014<br>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**.