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
HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number
M4-11-4527-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
AUGUST 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MFG in state of Texas allows $469.56 for reimbursement of this code. The amount paid is the rental allowable. This is for purchase of the NMES unit."

Amount in Dispute: $352.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical dispute concerns reimbursement for a neuromuscular stimulator. The requestor billed $498.00 for the device, and alleges it is entitled to reimbursement in the amount of $469.56. The carrier determined the correct reimbursement rate is $117.38. As noted on the most recent EOB that was generated in response to the billed charge, the requestor has not submitted sufficient documentation to support additional reimbursement at this time. Specifically, the requestor must submit a manufacturer's invoice for this item. Once that is provided, the carrier can re-audit the bill. In the meantime, no additional reimbursement is due."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2011	HCPCS Code E0745NU Neuromuscular Stimulator	$352.18	$352.18

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 §134.203 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers Compensation State Fee Schedule Adjustment.
   - 16-Claim/service lacks information which is needed for adjudication.

- W4-No additional reimbursement allowed after review of appeal/reconsideration. Please submit a manufacturer's invoice for this item and a copy of the bill for our review. Request for reconsideration reviewed. No further payment recommended.

Issues

1. Is the requestor entitled to additional reimbursement for HCPCS codes E0745NU?

Findings

Per 28 Texas Administrative Code §134.203(d) "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."

HCPCS code E0745NU does not have a DMEPOS fee schedule. The Texas Medicaid fee schedule is $877.20; therefore, $877.20 X 125% for the purchase of HCPCS code E0745 is $1,096.50. The requestor is seeking a lesser amount of $469.56. The respondent paid $117.38. The difference between the MAR and amount paid is $352.18; this amount is recommended for 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 $352.18.

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 $352.18 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		06/10/2014
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.