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
Property & Casualty Ins Co of

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-14-1584-01

MFDR Date Received
February 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The fee guidelines were not met with the partial payment received from the carrier for this item."

Amount in Dispute: $77.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however, no position statement received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2013	Durable Medical Equipment	$77.63	$3.70

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out medical fee guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4141– The payment is based on the Texas Medicaid Home health Agency Fee Schedule.
   - 181 – Payment adjusted because this procedure code was invalid on the date of service.
   - 4142 – The billed service has no allowance in Texas Medicaid Home Health Agency Fee Schedule
   - B13 – Previously paid

Issues

1. Did the requestor support position for additional reimbursement?
2. Did the respondent support position for reduction in payment?

3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(b) states, "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…." Medicare Claims Processing Manual, Chapter 20, Section 3.1.2 states in pertinent part, "contractors pay 10 percent of the purchase price of the item for each of 2 months." Therefore, the disputed service will be reviewed by applicable rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.202(c)(2)(A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;," or
    a. DMEPOS Fee Schedule E0730, TX – 1/1/2013 – 12/31/2013 ($387.35 x 10%) = $38.74
    b. Rental allowable x DWC fee guidelines $38.74 x 125% = $48.43
3. The total allowable is $48.43 less the amount previously paid by the carrier of $44.73 leaves $3.70. This amount is recommended.

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 $3.70..

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 $3.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.