



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

Apria Healthcare, Inc.

Respondent Name

WC Solutions

MFDR Tracking Number

M4-14-3027-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claims denied as not medically necessary as the patient is able to bear some weight on her knee. While this may be true, the patient has a severe history of knee problems and two knee replacements. Please find attached claims for reconsideration and medical records. We strongly urge you to reconsider payment of these claims for the patient's wheel chair as medically necessary due to the patient needing it during her recovery period from her second knee surgery and temporarily following while she regained strength. Please also be advised that the wheel chair has been considered purchased for the patient and no longer billing as of 11/7/2013."

Amount in Dispute: \$1574.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, Apria Healthcare Inc had already billed for 2 months of the K0003-RR wheelchair rental for 9/7/12 – 10/6/12 and 10/7/12 – 11/6/12 charging \$305.76 per month...Reimbursement at the fee schedule was made for both months.

Starr Comprehensive Solutions maintains the position that preauthorization was required for continued rental from 11/7/12 – 11/7/13 as the billed charges exceeded \$500.00 on the second month.

Starr Comprehensive Solutions respectfully requests that dates of service 11/7/12 – 4/7/13 be dismissed as the division's MFDR section received this request on 6/3/14. These 6 dates of service are over the one year timely filing deadline as stated in rule 133.307(c)(1)(A)."

Response Submitted by: Starr Comprehensive Solutions, Inc., PO Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2012 – December 6, 2013	Lightweight Wheelchair	\$1574.46	\$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 §134.600 defines the services that require pre-authorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
 - 197 – Payment denied/reduced for absence of precertification/authorization.
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for any portion of the disputed charges?
2. Was preauthorization required/obtained prior to services billed?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is November 7, 2012 – December 6, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 3, 2014. This date is later than one year after dates of service November 7, 2012 – May 6, 2013 included in the dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file a portion of this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.
2. The insurance carrier denied disputed charges stating, "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)." A review of the submitted documentation finds that billed rental for the disputed services exceeded \$500.00 as of 11/6/2012. Therefore, preauthorization was required for services after this date. Reviewed documentation does not support that preauthorization was requested or obtained for dates of service May 7, 2013 – December 6, 2013.

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

Laurie Garnes
Medical Fee Dispute Resolution Officer

January 8, 2015
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.