



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Universal DME

**Respondent Name**

Indemnity Insurance Co of North

**MFDR Tracking Number**

M4-15-0025-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

September 2, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "On 10/25/2013 we submitted our claims for payment to Gallagher Bassett-223812 in the amount of \$519.47 via mail. We did not receive any correspondence from the carrier. We submitted the claims for payment on several occasions, copy of screen print enclosed for your review. Our claims are now denied for timely filing. We have attached copies of the proof of timely filing and invoice with the appeals that were submitted on 07/14/2014."

**Amount in Dispute:** \$446.92

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Request billed \$519.47. Carrier issued reimbursement of \$72.55, based on the applicable fee guidelines. It appears that Requestor is submitting billing for 7 units of a monthly rental without adequate explanations. If this is for several different months, those bills should be submitted with different dates of service and separately for each month. Carrier maintains that it has correctly calculated the reimbursement owed for these services."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2013	E0217	\$446.92	\$2.25

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
  - W1 – Workers compensation state fee schedule adjustment

## **Issues**

1. Did the requestor support their position?
2. What is the applicable rule that determines the applicable fee guideline?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The requestor states, "...Our claims are now denied for timely filing."
  - a. Review of the explanation of benefits submitted with MFDR request found no denials for timely filing
  - b. Claims were adjudicated by carrier in timely manner.

The Division finds the requestor's position is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Labor Code §134.203(b) 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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The carrier alleges that HCPCS code E0217 should be paid at a daily rate, for a seven day rental period. According to the *Medicare Pricing, Data Analysis and Coding* contractor, [www.dmepdac.com](http://www.dmepdac.com), this code is listed as "Inexpensive and routinely purchased." The rental (RR) allowable for the State of Texas is \$60.44.

Per the Centers for Medicare/Medicaid Claims Processing Manual, [www.cms.hhs.gov](http://www.cms.hhs.gov), Chapter 20, items in this category may be billed as follows: "30.1 - Inexpensive or Other Routinely Purchased DME (Rev. 1, 10-01-03), For this type of equipment, contractors pay for rentals or lump-sum purchases. However, with the exception of TENS (see 30.1.2), the total payment amount may not exceed the actual charge or the fee schedule amount for purchase." Also found in the Medicare Claims Processing Manual, Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies 130.8 - Installment Payments (Rev. 1, 10-01-03), "Where a beneficiary is purchasing an item through installments, the total price of the equipment item is reported on the first bill. Monthly payments are made (by the DMERC, carrier, FI or RHHI). The monthly amount is equivalent to the rental fee schedule amount and is paid until the fee schedule purchase price or actual charge has been reached, whichever comes first." The daily versus monthly rental is not applicable to this service. Therefore, the carrier's position of daily calculations is not supported.

For the submitted code (E0217, RR), the carrier included remark code W1 – "Workers' compensation jurisdictional fee schedule adjustment." 28 Texas Administrative Code §134.203 (d) states in pertinent part, "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;..." Per the 2013 DMEPOS fee schedule, <https://www.dmepdac.com/dmecsapp/do/feesearch>, the maximum allowable reimbursement will be calculated as follows; the allowable amount \$59.84 x 125% = \$74.80.

3. The total recommended payment for the services in dispute is \$74.80. This amount less the amount previously paid by the insurance carrier of \$72.55 leaves an amount due to the requestor of \$2.25. 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 \$2.25.

**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 \$2.25 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 11, 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.**