



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

Universal DME

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-15-0813-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

November 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim has been processed with a partial payment of \$48.90 and Texas Mutual feels as if they have reimbursed the claim fair and reasonable."

Amount in Dispute: \$86.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided a tens unit for a one month rental. Texas Mutual paid a fair and reasonable payment of \$48.90 based on its reading of Chapter 20, section 30.1.2, Medicare Claims Processing Manual and the purchase price information of code E0730 for Texas in the 2014 DMEPOS fee schedule. No additional payment is due."

Response submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2014	E0730 RR	\$86.10	\$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

- 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:
 - P5 – Based on payer reasonable and customary fees. No maximum allowable. Defined by legislated fee arrangement
 - 217B – Based on payer reasonable and customary fees
 - 193 – Original payment decision is being maintained

Issues

1. Is there an established fee schedule amount for services in dispute?

2. Is the requestor entitled to reimbursement?

Findings

1. Texas Administrative Code §134.202 states, in pertinent part “(b) 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.”

Review of the submitted documentation finds HCPCS code E0730 – RR was submitted on claim line. Per DMEPOS Fee Schedule the service in dispute is classified as “Inexpensive Routinely Purchased.” CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, Subchapter (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13) states, “In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months.”

Therefore, the division finds the service in dispute (E0730) fee schedule amount is the PDAC purchase amount divided by 10 or ($\$391.22 \div 10 = \39.12). The service in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 (c)(A) states in pertinent part, “To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: ... (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; Therefore the total MAR is calculated as follows DMEPOS fee schedule $\$39.12 \times 125\% = \48.90 . The carrier paid $\$48.90$, no additional payment 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

Date

March , 2015

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.