



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 LLC

Respondent Name

Accident Fund General Insurance

MFDR Tracking Number

M4-15-1808-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

February 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted the appropriate needed for review."

Amount in Dispute: \$135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier stands by its reasons for denial. Provider has not established that it is entitled to reimbursement of \$135.00 for code E0370-RR."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2014	E0730	\$135.00	\$48.90

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:
 - 181 – Payment adjusted because this procedure code was invalid on the date of service.
 - 254 – The billed service has no allowance in fee schedule/UCR.

Issues

- Is the Carrier's denial supported?
- What is the applicable rule pertaining to reimbursement?
- Is the requestor entitled to reimbursement?

Findings

1. The Carrier denied the disputed service as, 181 – “Payment adjusted because this procedure code was invalid on the date of service.” 28 Texas Administrative 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;” Review of the Centers for Medicare and Medicaid Services, Alpha Numeric HCPCS code listing, <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2014-Alpha-Numeric-HCPCS.html?DLPage=1&DLSort=0&DLSortDir=descending> , finds E0730 to be a valid code. The Carrier’s denial is not supported. Therefore the services in dispute will be reviewed per applicable Medicare payment policy and Division fee guidelines.
2. 28 Texas Labor 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;” Review of the DMEPOS fee schedule finds the following;
 - a. The Medicare, 2014, Texas Fee Schedule amount found at www.dmeptac.com/dmecsapp/do/feesearch, for submitted code (E0730) is \$391.22
 - b. Per Medicare Claims Processing Manual, Chapter 20, 30.1.2 , “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”
 - c. Submitted document from requestor titled, “delivery ticket” indicates “rental” of Tens unit. This signature date indicates 11-7-2014. Per Medicare Claims Manual instructions, this will be considered the first month of rental.

Therefore, per the CMS payment policy and Division fee guideline instructions, $\$391.22 \div 10 = \$39.12 \times 125\% = \$48.90$.
3. The total allowable reimbursement for the service in dispute is \$48.90. The Carrier previously paid \$0.00. An additional payment of \$48.90 is 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 \$48.90.

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 \$48.90 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April , 2015 Date
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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.