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
Texas Mutual Insurance

MFDR Tracking Number
M4-15-2114-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Work Compensation claim are to be reimbursed 125% of the Medicare allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 4th quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%."

Amount in Dispute: $57.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For its part the request has provided no rational basis for a rental charge of $135.00 nor shown in any fashion how its billed amount is fair and reasonable."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2014	E0217	$57.91	$57.91

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 §133.210 defines medical documentation
3. 28 Texas Administrative Code §134.203 set out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the requestor support medical claim with documentation?

2. What it the applicable rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor states in their position statement, "E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%." Per 28 Texas Administrative Code § 133.210 (a) states, "Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results…." Review of the providers submitted documentation finds;
    a. Delivery Ticket with date 12/17/2014, and in pertinent part, "1, Rental, E0217-ARS2000C/Hot Cold Therapy Unit
    b. Medical claim submitted contains "RR" modifier that is used to show, "DME is to be rented"

   The submitted medical claim indicates units of "7". However, the Division finds that the submitted documentation supports that one item of DME was delivered and is to be rented. One item will be allowed.
2. Per 28 Texas Administrative Code §134.203 (d) "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 submitted documentation finds
    a. Applicable fee schedule for date of service finds, "TX, RR, $60.44"
    b. Per Division guidelines the maximum allowable reimbursement = $60.44 x 125% or $75.55.

3. The total maximum allowable reimbursement is $75.55. The Carrier previously paid $17.64. The remaining balance of $57.91 is due to the provider.

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 $57.91.

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 $57.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		April , 2015
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.