



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME LLC

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-15-3346-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Workers Compensation claims are to be reimbursed 125% of the Medicare allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 2nd quarter 2014, E0217 RR is supposed to be reimbursed at \$60.44 per unit x 125%."

Amount in Dispute: \$476.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the bills in question were escalated and the review has been finalized. Our bill audit company has determined no further payment is due."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| April 7, 2015 | E0217 | \$476.31 | \$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 §133.210 defines medical documentation
- 28 Texas Administrative Code §134.203 set out the reimbursement guidelines for professional medical services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - No explanation of remittance code P1 provided

Issues

- 1. Did the requestor support medical claim with documentation?
- 2. What is 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 4-1-15, 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, \$61.35"
 - b. Per Division guidelines the maximum allowable reimbursement = \$61.35 x 125% or \$76.68.
- 3. The total maximum allowable reimbursement is \$76.68. The Carrier previously paid \$76.68. No additional payment is due to the provider.

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 | July , 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.