



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

American Hallmark Insurance Co

MFDR Tracking Number

M4-16-0072-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

September 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental); so therefore we did not need authorization."

Amount in Dispute: \$414.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Universal DME LLC is not entitled to reimbursement for HCPCS Code E0673 (Segmental gradient pressure pneumatic appliance, half leg) based on denial of the qualifying service E0675 billed in a prior medical bill submission for date of service 06/16/15."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2015	E0673	\$414.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 107 – Denied-qualifying svc not paid or identified
 - W3 – Appeal/reconsideration

Issues

1. Did the carrier raise a new issue?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "As such, per disability management rules under §137.100 the insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines." Texas Administrative Code §133.307 (2) states,

Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

Review of the submitted explanation of benefits finds insufficient evidence to support the Carrier presented the denied the disputed service for "excess of the Division treatment guideline" prior to the date the MFDR was filed. Therefore, the Carrier's position statement will not be considered in this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code 107 – "Denied – qualifying svc not paid or identified." 28 Texas Administrative Code §134.203 (b) states,

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 submitted information finds that code E0673 – "Segmental gradient pressure pneumatic device half leg." This appliance is used with a pneumatic compression device as a supply. The original claim contained the pneumatic compression device equipment rental. The rental was denied. The Medicare payment policy article found at, [https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52488&ver=4&ContrId=140&ContrVer=2&LCDId=33829&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+\(18003%2c+DME+MAC\)&DocType=Active&LCntrctr=140*2&IsPopup=y&](https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52488&ver=4&ContrId=140&ContrVer=2&LCDId=33829&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&IsPopup=y&) under "Coding Guidelines" states in relevant section, "Segmental gradient pressure pneumatic appliances (E0671-E0673) are appliances/sleeves which are used with a non-segmented pneumatic compressor..." As the pneumatic compressor was not paid or appealed by the requestor, no additional payment can be recommended.

3. The Division finds reimbursement for the requested service in dispute cannot be allowed as the services are directly related to another service that was not paid.

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

October , 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, 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 MFDR 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.