TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Universal DME LLC

**Respondent Name**
WC Solutions

**MFDR Tracking Number**
M4-16-0136-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
September 16, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "…appeal was denied stating original decision maintained that it has been paid at Texas Fee schedule when indeed it has not been."

**Amount in Dispute:** $966.66

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Starr Comprehensive Solutions, Inc. maintains its position that reimbursement was made in accordance with the TDI-DWC rules 134.1 and 134.203."

**Response Submitted by:** Starr Comprehensive Solutions Inc, P.O. Box 801464, Houston, TX 77280

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 1, 2015 | E0676 NU | $966.66 | $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**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P5 – Based on Payer reasonable and customary fees
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

**Issues**

1. What is the applicable rule that pertains to reimbursement?
2. Did the requestor support additional reimbursement is due?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute relates to durable medical equipment. The submitted code was E0676 –NU, "INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED." Because this code is not otherwise specified, no DMEPOS fee schedule was found therefore, the service in dispute is subject to the provisions of 28 Texas Administrative Code §134.1 (e) and (f) which states,

> Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
>
> (1) the Division's fee guidelines;
>
> (2) a negotiated contract; or
>
> (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.
>
> (f) Fair and reasonable reimbursement shall:
>
> (1) be consistent with the criteria of Labor Code §413.011;
>
> (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
>
> (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

2. Texas Administrative Code 133.307 (2) states,

> The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:
>
> (O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

Review of the submitted documentation finds that:

- The requestor's states, "On 9/03/2015 that appeal was denied stating original decision maintained that it has been paid at Texas fee schedule when indeed it has not been."
- The requestor states, "On 08/21/2015 we sent an appeal via fax #830-693-2729 for additional payment of $966.46." Insufficient information was found to support why this amount should have been paid.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.

- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish 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**

| | | |
|---|---|---|
| | | October 8, 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, 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**.