



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-0236-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Texas Workers Compensation claims are to be reimbursed at 125% of the Medicare allowable rate."

Amount in Dispute: \$1,399.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the dispute charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2015	E0217, L1832, A9901	\$1,399.93	\$76.69

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.
- 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 50 – These are non-covered services because this is not deemed a medical necessity by the payer

- 999 – Adjustor denial (ZK10)

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. How many units were provided?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Per the requestor all code but CPT code E0217 have been paid. This code will be the only code reviewed in this dispute. The carrier denied this disputed service as 50 – “These are non-covered services because this is not deemed a medical necessity by the payer.” 28 Texas Administrative Code 134.600 (c) states,

The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

28 Texas Administrative Code §134.600 (p) states, “Non-emergency health care requiring preauthorization includes: (9) all durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental);” Review of the submitted documentation finds;

- Document from Coventry Workers’ Comp Services dated July 30, 2015. “Requested service description; Continuous Cryo Unit for 7 days rental E0217, Certified quantity (1) durable medical equipment, Start date 07/27/15, End date 10/02/15.”

Based on the above the Division finds the carrier is liable for the service in dispute as a prior authorization was obtained thus the services deemed reasonable and necessary prior to providing the service.

2. 28 Texas Administrative Code §134.203 (d) requires that, “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;:

The 2015 – 3rd Quarter Texas DMEPOS Fee Schedule finds E0217 (RR) to be \$61.35. Per the above referenced rule the MAR is calculated as $\$61.35 \times 125\% = \76.69 per unit.

3. The requestor submitted a quantity of (7) on the medial bill. The requestor provided a copy of the “Delivery Ticket” showing “Qty (1), Rental, E0217-ARS2000C/Hot Cold Therapy Unit – Aqua Relief”. Review of the submitted documentation finds (1) unit is supported. The maximum allowable reimbursement will be calculated based on this unit amount.
4. The maximum allowable for the service in dispute is \$76.69. This amount is recommended.

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 \$76.69.

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 \$76.69 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November , 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.