



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

Texas Mutual Insurance

MFDR Tracking Number

M4-16-0265-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Workers Compensation claims are to be reimbursed at 125% of the Medicare allowable rate. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 3rd quarter 2014, E0217 RR is supposed to be reimbursed at \$60.44 per unit x 125%."

Amount in Dispute: \$535.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2015	E0217	\$535.08	\$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:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment
 - W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

- 193 – Original payment decision is being maintained
- 426 – Reimbursed to fair and reasonable
- 891 – No additional payment after reconsideration

Issues

1. What is the number of units supported by the submitted documentation?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 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 documentation finds

- Review of the submitted "Delivery Ticket" finds (1) Rental E0217-ARS2000C/Hot Cod Therapy Unit – Aqua Relief.
- Review of the submitted medical claim finds modifier (RR)
- Review of the 2015 – 3rd Quarter Texas DMEPOS Fee Schedule finds; E0217, RR, \$61.35

The maximum allowable reimbursement will be calculated for the (1) unit supported by the submitted documentation based on the applicable fee guideline.

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

3. The maximum allowable for the service in dispute is \$76.69. The carrier previously paid \$76.69. (Explanation of benefits dated August 19, 2015 show \$17.92, requestor affirmed additional payment of \$58.77.) No additional payment is recommended.

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 _____ 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.