



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

Star Insurance Co

MFDR Tracking Number

M4-16-0283-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

September 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 08/04/2015 we also submitted our claim in the amount of \$233.02. On 08/26/2015 we received a denial stating that claim not covered by payer or contractor. On 08/28/2015 we submitted our appeal via mail to the same address. Our appeal was denied on 09/18/2015 for the same reason. They are the correct payer and they have paid several other claims for us."

Amount in Dispute: \$507.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill is priced correct at Medicare DMEPOS at 125% plus a 10% incentive. The allowable is per months rental of code E0217, not for 7 days. This is a rental and DME HCPCs codes should be billed with 1 UOS per 30 days."

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
July 22, 2015 July 28, 2015	L3670, A9901 E0217	\$701.66	\$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

- 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:
 - 109 – Claim not covered by this payer/contractor (This denial not maintained)

- P12 – Workers’ Compensation State Fee Schedule Adj
- Z710 – The charge for this procedure exceeds the fee schedule allowance
- W3 – Request for reconsideration
- 193 – Original payment decision is being maintained
- 216 – Based on findings of a review organization
- P300 – The amount paid reflects a fee schedule reduction

Issues

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

Findings

1. The services in dispute are related to durable medical equipment. 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 the following;

- L3670 allowable $\$102.82 \times 125\% = \128.53
- E0217, RR allowable $\$61.35 \times 125\% = \76.69
- A9901 - The Medicare Claims processing manual, Chapter 20, has specific details in regards to delivery of DME items found at www.cms.hhs.gov, and states, “60 - Payment for Delivery and Service Charges for Durable Medical Equipment (Rev. 1, 10-01-03) B3 – 5105 Delivery and service are an integral part of oxygen and durable medical equipment (DME) suppliers' costs of doing business. Such costs are ordinarily assumed to have been taken into account by suppliers (along with all other overhead expenses) in setting the prices they charge for covered items and services. As such, these costs have already been accounted for in the calculation of the fee schedules. Also, most beneficiaries reside in the normal area of business activity of one or more DME supplier(s) and have reasonable access to them. Therefore, DME carriers may not allow separate delivery and service charges for oxygen or DME except as specifically indicated in §§90 or in rare and unusual circumstances when the delivery is not typical of the particular supplier's operation. No additional payment is recommended.

The total allowable reimbursement is \$205.22. This amount is recommended.

2. The maximum allowable for the services in dispute is \$205.22. The carrier previously paid \$302.88. 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 23, 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.