



# 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

**Respondent Name**

Hartford Casualty Insurance Co

**MFDR Tracking Number**

M4-16-0388-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

October 14, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We should be paid for services rendered because we have submitted the appropriate paperwork for this review."

**Amount in Dispute:** \$414.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Based on documentation received, Coventry stands behind our review. A bill was sent in on 8/24/15 from the physician under DCN 2015219F2097009. The documentation is attached. This physician is the provider that actually provided the equipment to the patient. ...Universal DME did not provide the equipment to the claimant and is therefore not due allowance for the charges."

**Response Submitted by:** Gallagher Bassett Services, Inc

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 23, 2015	E0673 NU	\$414.00	\$372.06

#### 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:
  - M125 – DME items may not be rented after having been previously purchased, nor purchased more than once. This HCPCS code has previously been paid as a purchased item for this patient and Date of

Injury, and should not be reimbursed again. Please correct and resubmit billing if billed in error.

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Request for reconsideration
- 18 – Duplicate claim/service

### **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. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The carrier denied the services in dispute as 18 – “Duplicate claim/service,” M125 – “DME items may not be rented after having been previously purchased, nor purchased more than once. This HCPCS code has previously been paid as a purchased item for this patient and Date of Injury, and should not be reimbursed again” and B13 – “Previously paid. Payment for this claim/service may have been provided in a previous payment. Please correct and resubmit billing if billed in error.” Review of the submitted documentation finds;

- a. Delivery ticket with signature date June 23, 2015 showing delivery of (1), Purchase, E0673-3040/VenaFlow/Calf Cuff to claimant at their address.

The carrier states in their position statement that, “A bill was sent in on 8/24/15 from the physician under DCN 2015219F2097009. The documentation is attached.” Insufficient evidence was found to support this statement and the denials for reason codes shown above. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.203(d) states, “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;” Review of the 2015 – 1<sup>st</sup> Half Texas DMEPOS fee schedule finds the allowable to be \$297.65. The maximum allowable reimbursement is calculated as follows;

$$\text{DMEPOS fee schedule} \times 125\% \text{ or } \$297.65 \times 125\% = \$372.06$$

3. The maximum allowable reimbursement for the service in dispute is \$372.06. 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 \$372.06.

**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 \$372.06 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.**