



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME LLC

Respondent Name

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-16-0476-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

October 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted appropriate paperwork needed for review along with authorization #41738369-UMO-6."

Amount in Dispute: \$483.98

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "HCP has been reimbursed at the monthly rate and is not due seven times the monthly rental value as requested."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2015	E0218/E0217 -RR	\$483.98	\$7.67

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 State Fee Schedule Adj
 - 45 – Contract/Legislated Fee Arrangement Exceeded
 - RR – Rented equipment
 - W3 – Request for reconsideration

- RA6 – Procedure Billing Restricted/Once per 30 days
- 193 – Original payment decision maintained
- B13 – Payment for service may have been previously paid

Issues

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

Findings

1. The requestor submitted the DWC060 with E0218/E0217 listed as treatment or Service Codes in Dispute. Review of the submitted documentation finds; Delivery Ticket dated June 17, 2015, Qty (1), Type – Rental, Item – E0217-ARS200C / Hot Cold Therapy Unit – Aqua Relief. This code is supported and will be reviewed as the service in dispute.
2. 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 – 1st Half Texas DMEPOS Fee schedule finds the following;

- E0217, RR allowable (1) unit \$61.35 x 125% = \$76.69

The total allowable reimbursement is \$76.69.

3. The maximum allowable for the services in dispute is \$76.69. The carrier previously paid \$69.02. The remaining balance of \$7.67 is due to the requestor.

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 \$7.67.

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 \$7.67 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	December , 2015 Date
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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.