



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

Texas Municipal League

MFDR Tracking Number

M4-16-0479-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: We are still owed a balance of \$79.77 for E0748 and \$1500.00 for E0676. We did have authorization for these services.

Amount in Dispute: \$1,579.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The carrier is in the process of sending additional payment to the provider. If the provider should receive the full amount it is requesting through medical dispute resolution, then the carrier requests that the provider withdraw its request for medical dispute resolution."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 25, 2015, E0748 -NU, E0676 -NU, \$1,579.77, \$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

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets for the provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 97 – Payment is included in the allowance for another service/procedure

- 39 – Services denied at the time authorization/pre-certification was requested
- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 217 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. Provider failed to submit requested manufacturer’s invoice.
- 462 – Service exceeds the Official Disability Guidelines (ODG) level of care (Not maintained at re-consideration)

**Issues**

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. Did the requestor meet requirements of Rule 133.307?
3. Is the requestor entitled to additional reimbursement?
4. Was the remaining service in dispute paid per applicable rule and fee guideline?

**Findings**

1. The insurance carrier reduced dispute service E0676 –NU with claim adjustment reason code CAC -217- “Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.”

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;
- (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
- (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the 2015, Texas, DMEPOS fee schedule finds no allowable for this code in dispute. Review of the 2015, Texas, Medicaid fee schedule finds no allowable listed for code E0676.

28 Texas Administrative code 134.203 (f) states,

For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

28 Texas Administrative Code §134.1(f) states,

Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011 (d) states,

Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of

the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf.

The carrier has supported their position in how the provisions of Rule 134.1 and Labor Code 413.011 apply.

2. 28 Texas Administrative Code 133.307 (c)(2)(O), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;” Review of the submitted documentation finds that:

- The requestor submitted no position statement that asserts that fair and reasonable reimbursement would be 100% of total billed charges.
- The requestor did not support that additional reimbursement of \$966.47 (\$1500.00 in dispute less the payment made on November 13, 2015 of \$533.53) would be fair and reasonable rate of reimbursement for the service in this dispute.
- The requestor did not support that payment of the request amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The request for additional reimbursement for code E0676 -NU is not supported. Thorough review of the submitted documentation finds insufficient evidence to demonstrate or justify that payment sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

4. The remaining code in dispute is E0748 – NU. 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, Texas, DMEPOS fee schedule finds the allowable for E0748, NU is \$4,318.48. This amount x 125% = \$5,398.10. The carrier made a payment in the amount of \$5,318.33 on October 2, 2015 and an additional payment of \$79.77 on November 13, 2015 for a total payment of \$5,398.10. As these payments total the MAR no additional payment can be recommended.

### **Conclusion**

The Division would like to emphasize that individual medial fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. 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

December 8, 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.**