



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

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-0564-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted appropriate proof of timely filing and we have included all supporting documentation including our authorization #11057210."

Amount in Dispute: \$553.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has now been reprocessed for the allowable of \$76.69. Per our Fee Schedule team, this allowable is correct."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2015	E0217	\$553.00	\$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
 - 1 – This item was previously submitted and reviewed with a notification of decision issue to payor, provider (duplicate invoice)

Issues

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

Findings

1. The service in dispute is related to durable medical equipment. Review of the submitted "Delivery Ticket" finds (1) Rental E0217-ARS2000C/Hot Cod Therapy Unit – Aqua Relief. The requestor submitted a total of 7 units. The medical fee dispute will be reviewed based on applicable rules and fee guidelines for the number of units supported by the submitted documentation of (1) unit.
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;
- (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;

The 2015 – 3rd Quarter Texas DMEPOS Fee Schedule finds the allowable for E0217 (RR) of \$61.35. Therefore, the Maximum Allowable Reimbursement (MAR) will be the Texas DMEPOS Fee Schedule, found at www.cgsmedicare.com which is \$61.35 x 125% for (1) unit = \$76.69.

3. The maximum allowable for the service in dispute is \$76.69. The carrier previously paid \$76.69. 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	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.