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
ACG Medical Supply

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-0521-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We filed the bill and were not paid the MSRP amounts on all but one item. The E0277 was the only item that paid correctly at the MSRP amount of $3774.60."

Amount in Dispute: $8,728.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not shown that $2,440.28, the MSRP, is fair and reasonable. The requestor has not shown that $5,001.73, the MSRP is fair and reasonable. The requestor has not shown that $5,001.73, the MSRP, is fair and reasonable."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2015	E0635, E0240, E0265	$8,728.01	$1,034.56

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P5 – Based on payer reasonable and customary fees. No maximum allowable
   - 426 – Reimbursed to fair and reasonable
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline

- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 426 – "Reimbursed to fair and reasonable." 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.
   > >
   > > (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   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).

   Review of the submitted information finds that the services in dispute are durable medical equipment. Further review of the Texas Medicaid fee schedule finds a listed fee. Therefore, the insurance carrier's denial reason is not supported. The disputed services will be reviewed per applicable Division 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;
   > >
   > > (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;

   Review of the Medicare DMEPOS fee schedule finds no allowable based on the submitted modifier. Review of the Texas Medicaid fee schedule does find an allowable for the submitted codes/modifiers in dispute. The maximum allowable reimbursement will be calculated as follows;

Date of Service	Submitted Code	Submitted Charge	Texas Medicaid fee schedule amount x 125%	Amount Paid	Amount due
July 15, 2015	E0635 NU	$5,001.73	$1,765.53 x 125% = $2,206.91	$1,697.60	$509.31
July 15, 2015	E0240 NU	$1,286.00	$1,434.28 x 125% = $1,792.85	$1,093.10	$699.75

July 15, 2015	E0265 NU	$2,440.28	$1,772.72 x 125% = $2,215.90	$2,390.40	(-174.50)
		Total	$6,215.66	$5,181.10	$1,034.56

3. The maximum allowable reimbursement for the services in dispute is $6,215.66. The carrier previously paid $5,181.10. The remaining balance of $1,034.56 is due to the requestor. 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 $1,034.56.

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 $1,034.56 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.