



**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**

Hanover Insurance Co

**MFDR Tracking Number**

M4-16-0564-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

November 2, 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 # 50933587 UMO38."

**Amount in Dispute:** \$507.94

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Because this service is reimbursable per month rather than per day the allowed number of units will be one. The requestor's position is not supported."

**Response Submitted by:** Corvel

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2015	E0218	\$507.94	\$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:
  - 150 – Payment adjusted/unsupported service level
  - 16 – Svc lacks info needed or has billing error(s)
  - P12 – Workers' Compensation State Fee Schedule Adj

- RA5 – Procedure billing restricted/once per 30 days

### **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 services in dispute are related to durable medical equipment. Review of the submitted documentation finds the requestor submitted medical claims with two codes E0217 - Water circulating heat pad with pump and E0218 – Water circulating cold pad with pump on the DWC 0060. Review of the submitted “Delivery Ticket” finds (1) Rental E0217-ARS2000C/Hot Cod Therapy Unit – Aqua Relief. The Division finds the submitted documentation supports the submitted medical claim for code E0217. However, the respondent reimbursed after a “corrected” claim was submitted under E0218. This code is also found on the DWC060 form submitted to the Division with the request for Medical Fee Dispute. This code will be reviewed in this dispute.
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 – 3<sup>rd</sup> Quarter Texas DMEPOS Fee Schedule finds no listing E0218 (RR). Therefore, the Maximum Allowable Reimbursement (MAR) will be the Texas Medicaid Fee Schedule, found at [www.tmhp.com](http://www.tmhp.com) which is \$36.05 x 125% for (1) unit = \$45.06.
3. The maximum allowable for the service in dispute is \$45.06. The carrier previously paid \$45.06. 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

\_\_\_\_\_  
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.**