



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

M4-16-0763-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: November 11, 2015, "We should be paid for services rendered because we have submitted the appropriate paperwork needed..."

December 29, 2015, "E0935 was paid in full, A9901 is paid in full, but E0188 still has a balance owed of \$31.18. That code has not been paid."

Amount in Dispute: \$615.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. Payment of \$441.70 was made on 12/12/15. That may resolve the dispute. Provider may withdraw request."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2015	E0935, E0188, A9901	\$615.60	\$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.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 109 – Claim not covered by the payor/contractor
 - 18 – Duplicate claim/service

Issues

1. What is the service in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (b) requires that,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of the submitted information finds that the submitted code "E0188" has a narrative description of "Synthetic sheepskin pad" per DMEPOS Fee Schedule found at www.cgs.medicare.com . The narrative description from the "Delivery Ticket" states, "E0188-20533 / CPM Kit Knee Optiflex." Insufficient information was found to support the services as billed. No additional payment can be recommended.

2. Pursuant to Rule 134.203 (b)(1) no additional payment is recommended for the services in dispute.

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 30, 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.