



**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**

Ace American Insurance Co

**MFDR Tracking Number**

M4-16-1161-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

January 4, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We should be paid for services rendered because we have submitted the appropriate paperwork for review."

**Amount in Dispute:** \$913.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The carrier has reconsidered the bill and no additional payment has been recommended."

**Response Submitted by:** Broadspire, P.O. Box 14351 Lexington, KY 40512-4351

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2015	E0673 -RR, E0675 -NU	\$913.00	\$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:
  - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
  - B50 – No reimbursement recommended as this service should be included in the hospital/asc billing
  - D98 – reimbursement not recommended in accordance with the official fee schedule guidelines

- D00 – Based on further review, no additional allowance is warranted

## Issues

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

## Findings

1. The services in dispute are considered "durable medical equipment." The insurance carrier denied disputed services with claim adjustment reason code B50 – "No reimbursement recommended as this service should be included in the hospital/asc billing." 28 Texas Administrative Code §134.203 (b) states,

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; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Per the Centers for Medicare and Medicaid, "Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 30 - General Payment Rules, B3-5102, found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf> states in pertinent part,

*The definition of DME in §1861(n) of the Act provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF or hospital. (See the Medicare Benefit Policy Manual, Chapter 15). This does not preclude separate billing for DME furnished after discharge.*

The Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, D. Definition of a Beneficiary's Home, found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> states in pertinent part,

*For purposes of rental and purchase of DME a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for the mentally retarded (ICF/MR)). However, an institution may not be considered a beneficiary's home if it:*

- *Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or*
- *Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.*

*Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in the bullets above, the individual is not entitled to have separate Part B payment made for rental or purchase of DME. This is because such an institution may not be considered the individual's home. The same concept applies even if the patient resides in a bed or portion of the institution not certified for Medicare.*

Review of the submitted medical claim finds the place of service listed in box 24B of the Form 1500 is "22" or outpatient hospital. Based on the above referenced Medicare payment policy, the carrier's denial is supported.

2. Pursuant to requirements of Rule 134.204(b) 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**

		January , 2016
Signature	Medical Fee Dispute Resolution Officer	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.**