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
Star Insurance Co

MFDR Tracking Number
M4-16-1574-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
February 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we received a denial from Gallagher Bassett stating they are "not correct payer", when indeed they are..."

Supplemental dated March 22, 2016: They did make a payment of $45.25 but we are still owed a balance of $89.75.

Amount in Dispute: $135.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per bill review department, additional allowance was recommended. An adjustment has been processed and case id# OR141605714308 (additional $45.25) was finalized in our system today."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2015	E0730	$135.00	$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

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. 28 Texas Administrative Code §133.308 details requirements of medical necessity disputes.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Service to be reviewed for payment by DME informal or voluntary network, Coventry DMEplus as defined in Texas Labor Code 408.0284
   - 2 – Original payment decision is being maintained

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 10 – "Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor" and 21 – "Based on the findings of a review organization." 28 Texas Administrative Code §133.308(o) states in pertinent part, "The decision shall be mailed or otherwise transmitted to the parties and to representatives of record for the parties and transmitted in the form and manner prescribed by the department within the time frames specified in this section." Review of the submitted documentation found insufficient documentation to support the service in dispute had been reviewed and/or denied by a review organization and no indication that the wrong carrier had been billed. The Division finds the carrier's denial is not supported. The service in dispute will be reviewed per applicable rules and fee guidelines.

2. 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;

   Review of the applicable Medicare policy found at, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), which states;

   In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay 10 percent of the purchase price of the item for each of 2 months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

   28 Texas Administrative Code §134.203 (d) states in pertinent part,

   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;

   Review of the 2015 – 4th Quarter Texas DMEPOS Fee Schedule finds E0730 RR is 397.07 ÷ 10 = $39.71. The maximum allowable reimbursement is calculated to be ($39.70 x 125% = $49.63). The amount is recommended.

3. The total allowable reimbursement is $49.63. The carrier previously paid $45.25. 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 additional reimbursement for the services in dispute.

Authorized Signature

		March 23, 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.