



**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**

AIG Assurance Co

**MFDR Tracking Number**

M4-16-1786-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

February 26, 2016

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We did have authorization #12134873."

Supplemental response: April 6, 2016: "We received a partial payment. They only paid \$76.69 for code E0217. The balance remaining is \$476.31. The code E0675 was paid in full."

**Amount in Dispute:** \$1,052.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Additional payments issued."

**Response Submitted by:** Gallagher Bassett Services, Inc

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2015	E0675, E0217	\$1,052.00	\$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:
  - 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
  - W3 – Request for reconsideration

**Issues**

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

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code 1 – Service to be reviewed for payment by DME informal or voluntary network, Coventry DMEplus as defined in Texas Labor Code 408.0284. Texas Labor Code §408.0284(b) states

Notwithstanding any provision of Chapter 1305, Insurance Code, or Section 504.053 of this code, durable medical equipment and home health care services may be reimbursed in accordance with the fee guidelines adopted by the commissioner or at a voluntarily negotiated contract rate in accordance with this section.

Review of the submitted information finds that:

- No Carrier relationship was found between the carrier and Coventry Health Care Workers on the DME and Home Health Informal Networks Report found at [https://wwwapps.tdi.state.tx.us/inter/perlroot/sasweb9/cgi-bin/broker.exe?\\_service=wcExt&\\_program=progext.DME\\_HomeHealth\\_networkrpt.sas](https://wwwapps.tdi.state.tx.us/inter/perlroot/sasweb9/cgi-bin/broker.exe?_service=wcExt&_program=progext.DME_HomeHealth_networkrpt.sas) as suggest by denial remark

The respondent did not submit a copy of the alleged contract. The respondent did not submit documentation to support requirements of Texas Labor Code 408.0284(c), which states in pertinent part, “The carrier has a contractual arrangement between (1) the carrier or authorized agent and the informal or voluntary network that authorized the network to contract with health care providers for durable medical equipment or home health care services on the carrier’s behalf; and (2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements of this section.”

The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (b) states in pertinent part,

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;

- 28 Texas Labor Code §134.203 (d) and (f) states in pertinent parts,

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 DMEPOS fee schedule finds the following;

- a. The Medicare, 2015 4<sup>th</sup> Quarter, Texas Fee Schedule amount found at [www.dmeptac.com/dmecsapp/do/feesearch](http://www.dmeptac.com/dmecsapp/do/feesearch), for submitted codes is as follows:
  - E0675 –RR, \$426.83 x 125% = \$521.04 (requestor is seeking \$499.00, this amount is recommended).
  - E0217 –RR, \$61.35 x 125% = \$76.69(Delivery ticket 10170, only supports (1) unit provided)

Total	\$576.59
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3. The maximum allowable for the services in dispute is \$575.69. The carrier made a payment in the amount of \$575.69 per supplemental position statement dated April 6, 2016 from requestor and copies of payment from carrier dated March 21, 2016. 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

April 8, 2016

**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.**