



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

Indemnity Insurance Co of North

MFDR Tracking Number

M4-16-1902-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

March 7, 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 along with all supporting documentation."

Amount in Dispute: \$913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find an EOB and payment history showing payment was issued to the Provider for the CPT codes E0673 and E0675 on 3/23/15. Payment was made pursuant to the fee guidelines."

Response Submitted by: Downs ♦ Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2015	E0673, E0675	\$913.00	\$496.33

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:
 - W3 – Additional payment made on appeal/reconsideration
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 948 – Re-reviewed at providers request with additional information and documentation/additional payment suggested.

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Labor Code §134.203 (d) 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 4th Quarter, Texas Fee Schedule amount found at www.cgsmedicare.com/medicare_dynamic/fees/jc/results.asp, for submitted codes is as follows:

- E0675 – RR, \$426.83 x 125% = \$533.54
- E0673 – NU, \$297.65 x 125% = \$372.06
- Total \$905.60

2. The maximum allowable for the services in dispute is \$905.60. The carrier submitted evidence a payment was received in the amount of \$409.27 for the services in dispute. The remaining balance if \$496.33. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$496.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$496.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2016 Date
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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.