



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

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-2350-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

April 11, 2016

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$188.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid \$36.14, a fair and reasonable reimbursement for one month rental.the requestor billed code E1399-NU for a pulley set. Texas Mutual denied payment on the basis of incorrect coding of the pulley set."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2016	E0730, E1399-P9633	\$188.86	\$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 services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – workers' compensation jurisdictional fee schedule adjustment.
 - P5 – Based on payer reasonable and customary fees. No maximum allowable.
 - 426 – Reimbursed to fair and reasonable.

- 714 – Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from DOS.
- 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the rule applicable to reimbursement?
2. Is the carrier’s denial supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier reduced the disputed service E0730 with claim adjustment reason code(s) P5 – “Based on payer reasonable and customary fees. No maximum allowable” and 426 – “reimbursed to fair and Reasonable.” 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) 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 DMEPOS fee schedule finds the following;

- a. The Medicare, 2016 Texas Fee Schedule amount found at www.dmeptac.com/dmecsapp/do/feesearch, for submitted code (E0730) is \$289.12
- b. Per Medicare Claims Processing Manual, Chapter 20, 30.1.2 , “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”
- c. Submitted document from requestor titled, “delivery ticket” indicates “rental” of Tens unit. Date received (signature of injured worker) was January 28, 2016. This date of service will be considered the first month based on the Medicare Claims Processing Manual instructions.

Therefore, per the CMS instructions and Division fee guidelines, $\$289.12 \div 10 = \$28.91 \times 125\% = \$36.14$.

2. The insurance carrier denied the disputed service E1399 as 714 – “Accurate coding is essential for reimbursement. CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from DOS.” Review of the www.dmeptac.com/dmecsapp/do/feesearch, finds the following:

E1399 - Long Description: DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS.

Review of the submitted documentation finds: Delivery Ticket, 10302 details the following; E1399 – P9634 / Exercise Pedal and E1399-P9633 / 9633 exercise Pulley Set. As the submitted code was not supported based on the detailed description found on the delivery ticket, the carrier’s denial is supported.

3. The total maximum allowable reimbursement for the services in dispute is \$36.14. The carrier previously paid \$36.14. 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 , 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.