



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

Zurich American Insurance Co

MFDR Tracking Number

M4-16-2943-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 25, 2016

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$74.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the bill, Coventry Bill Review makes the stand that nothing more is owed..."

Response Submitted by: Gallagher Bassett Services, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2016	E0730 RR	\$74.61	\$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 – The amount paid reflects the usual and customary charge
 - 4 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

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. 28 Texas Administrative Code §134.203 (b) requires that “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;”

The applicable Medicare payment policy is found at, www.cms.hhs.gov, Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)30.1.2 - Transcutaneous Electrical Nerve Stimulator (TENS) (Rev. 2605, Issued: 11-30-12, Effective: 06-08-12, Implementation: 01-07-13), “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.” Review of the submitted “Delivery Ticket” shows a delivery date of July 28, 2015 and the “type” of “Rental”. Per the Medicare policy, this will be considered the first month of the trial period.

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 2016 – 1st Quarter Texas DMEPOS Fee Schedule finds E0730 RR is $289.12 \div 10 = \$28.91$. The maximum allowable reimbursement is calculated to be $(\$28.91 \times 125\% = \$36.14)$. This is the maximum allowable reimbursement per applicable Division fee guideline.

2. The total allowable reimbursement is \$36.14. The carrier previously paid \$60.39. 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

June , 2016
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.