



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME Inc

Respondent Name

Travelers Casualty & Surety Co

MFDR Tracking Number

M4-16-3412-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

July 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have given Travelers Insurance several opportunities to resolve this claim. We feel that these charges are due to us as you will see in our supporting documentation. We should be paid for services rendered because we have submitted the appropriate paperwork needed for review."

Amount in Dispute: \$98.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to additional reimbursement for the disputed services at their full billed charge. The Carrier has reviewed the documentation and determined the Provider has been appropriately reimbursed under the Division's adopted DME fee schedule. The Carrier believes no additional reimbursement is due."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 29, 2016, E0730, \$98.86, \$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

- 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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
  - P12 – Workers’ Compensation jurisdictional fee schedule adjustment
  - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
  - 947 – Upheld no additional allowance has been recommended
  - 863 – Reimbursement is based on the applicable reimbursement fee schedule

**Issues**

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

**Findings**

1. The insurance carrier denied disputed services with claim adjustment reason code P12 – Workers’ Compensation Jurisdictional fee schedule adjustment.” 28 Texas Administrative Code §134.203 (d) states,  
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;For the service in dispute E0730 – Tens, review of the Medicare Claims Processing Manual, [www.cms.hhs.gov](http://www.cms.hhs.gov), Chapter 20, Section 30.1.2, states in pertinent part, “Pay 10 per cent of the purchase price for each of 2 months.” The 2016 1<sup>st</sup> Quarter Texas DEMPOS Fee Schedule finds the allowable for the purchase to the \$289.12. Per the above, this allowable divided by 10 equals a monthly allowable for the first two months of \$28.91. Therefore pursuant to provisions of Rule 134.203(d)(1) the monthly allowable is (\$28.91x 125%) = \$36.14.
2. The total allowable for the service in dispute is \$36.14. The carrier previously paid \$36.14. No additional payment is due.

**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

\_\_\_\_\_  
August , 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.**