



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

Arch Insurance Co

MFDR Tracking Number

M4-16-3468-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In the appeal we explained that Code E0673 is used one time after being purchased then gets disposed after surgery."

Amount in Dispute: \$414.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett Services, Inc., 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 29, 2016, E0673- NU, \$414.00, \$370.58

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 services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 1 – DME items may not be rented after having been previously purchased, nor purchased more than once. This HCPCS code has previously been paid as a purchased item for this patient and Date of Injury, and should not be reimbursed again. Please correct and resubmit billing if billed in error.
- 2 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 3 – Request for reconsideration

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 1 – "DME items may not be rented after having been previously purchased, nor purchased more than once. This HCPCS code has previously been paid as a purchased item for this patient and Date of Injury, and should not be reimbursed again." Review of the submitted documentation finds insufficient evidence to support that the equipment had been previously purchased. Therefore, the insurance carrier's denial reason is not supported. The disputed services will be reviewed per applicable Division rules and fee guidelines.
2. 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:
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 First Quarter Texas DMEPOS fee schedule finds for E0673-NU the allowable is \$296.46. The maximum allowable reimbursement is as follows: $\$296.46 \times 125\% = \370.58 .
3. The total allowable for the service in dispute is \$370.58. The carrier previously paid \$0.00. The remaining balance of \$370.58 is due to the requestor.

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 \$370.58.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 \$370.58, 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

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.