



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 LLC

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-16-3714-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have given Gallagher Bassett multiple opportunities to resolve this claim. We feel that these charges are due to us as you will see in our supporting documentation."

Amount in Dispute: \$476.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: E0217/RR is priced correct to \$76.99 per Texas DME pricing to CMS DMEPOS 2015.

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2015	E0217, RR	\$476.31	\$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 – Rental reimbursements have not reached the threshold value or the rental payments have been reimbursed less than maximum number of occurrences.
 - 3 – The charge for this procedure exceeds the fee schedule allowance (Z710)

- 1 – DME Rental items are not to be billed more than once per month. This HCPCS code has previously been paid as a rental item for this patient and Date of injury.

Issues

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

Findings

1. 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 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;

- The Medicare, 2015 4th Quarter, Texas Fee Schedule amount found at www.dmeprd.com/dmecsapp/do/feesearch, for submitted code is as follows:
 - E0217 –RR - \$61.35 (1) unit. Review of submitted delivery ticket supports one unit not seven as submitted on medical claim. $\$61.35 \times 125\% = \76.69
 - Total allowable = \$76.69

2. The maximum allowable for the services in dispute is \$76.69. The carrier previously paid \$76.69. 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

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.