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
Duramed Inc

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-18-2999-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has never been paid in full."

Amount in Dispute: $98.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This HCPCS code has previously been paid as a purchased item for this patient and Date of Injury, and should not be reimbursed again."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2017	E0215 – NU	$98.59	$98.59

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 durable medical equipment services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment

Issues

1. Is the carrier's position statement supported?
2. What rule is applicable to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B13 – "Previously paid. Payment for this claim/service may be been provided in a previous payment." The carrier states in their position statement, "This HCPCS code has previously been paid as a purchased item for this patient and Date of Injury…"

   Review of the submitted documentation found insufficient evidence to support the previous payment for this durable medical equipment. The claim in service will be reviewed per applicable fee guideline.

2. 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 DMEPOS fee schedule found at www.cms.gov, finds the allowable for E0215, NU is $78.87. This amount multiplied by 125% = $98.59. This amount is recommended.

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 $98.59.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $98.59, 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	July 6, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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. **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.