



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

Orthotexas Physician and Surgeon

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-18-4573-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

July 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was given Arm Cradles which is a "cash-pay" item in our office. This is now being billed to your company under the CPT code A9999. Miscellaneous DME supply. I am resubmitting this claim(s) for payment reconsideration. I have also included in this submission the medical documentation."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier denied reimbursement on the basis that there was no supporting documentation indicating the arm cradles had been prescribed or supplied, nor was there any documentation supporting the type of arm cradle or the cost. As the Provider has still not submitted any supporting documentation for the alleged arm cradles, the Provider is not entitled to reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 30, 2018, A9999, \$100.00, \$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. 28 Texas Administrative Code §134.1(f) which details medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information which is needed for adjudication
 - 8 – The supply charge was disallowed as it was not adequately identified. Please resubmit with invoice
 - W3 – Additional payment made on appeal/reconsideration

Issues

1. What is the applicable fee rule?
2. Did the requestor provide documentation to support requested payment amount?

Findings

1. The requester seeks additional reimbursement in the amount of \$100.00 for code A9999 (Miscellaneous DME Supply) dispensed on March 30, 2018. The carrier reduced the payment with the following reason codes 16 – “Claim/service lacks information which is needed for adjudication.”

Durable medical equipment is addressed in 28 Texas Administrative Code 134.203(d)(3) which 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;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the applicable DMEPOS fee schedule finds no fee schedule amount for A9999.

Review of the Texas Medicaid fee schedule finds no fee schedule amount for A9999.

The service in dispute will be reviewed pursuant to 28 Texas Administrative Code §134.203(f) which states,

For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

2. Based on the above 28 Texas Administrative Code §134.1(f) applies and states, Fair and reasonable reimbursement shall:
 - (1) be consistent with the criteria of Labor Code §413.011;
 - (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
 - (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 Texas Administrative Code §133.307(c)(2)(O) also applies and, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.”

Review of the submitted documentation finds:

- The requestor does not discuss or demonstrate how reimbursement of \$100.00 for code A9999 is a fair and reasonable reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1(f). For that reason, no reimbursement can be 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 24, 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 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.