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
Fondren Orthopedic Group

Respondent Name
Sherwin Williams Co

MFDR Tracking Number
M4-19-2451-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Texas Fee Schedule we are underpaid for this code. The allowable amount is $5509.39."

Amount in Dispute: $431.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been determined that services were overpaid as they were not issued according to the guidelines provided by the Texas Medical Fee Schedule."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2018	E0747	$431.02	$431.02

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:
   - P301 – Based on payer reasonable and customary fees

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?

Findings

1. The requestor is seeking $431.02 for durable medical equipment dispensed on April 10, 2018. The insurance carrier reduced the disputed services with claim adjustment reason code P301 – "Based on payer reasonable and customary fees."

   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 for date of service April 10, 2018 found at https://www.dmepdac.com/ finds an allowable of $4,407.51. This allowable multiplied by 125% = $5,509.39. The carrier paid $5,078.37. The balance of $431.02 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 $431.02.

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 $431.02, 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	February 8, 2019 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.