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
Crown Medical Billing

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-5315-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $6,467.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2019	E0676	$6,467.79	$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 guidelines for reimbursement of professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 426 – Reimbursed to fair and reasonable
   - P5 – Based on payer reasonable and customary fees no maximum allowable. Defined by legislated fee arrangement

Issues

Is the insurance carrier's reason for reduction of payment supported?

Findings

The requestor is seeking additional reimbursement $6,467.79 for Code E0676 - Intermittent limb compression device (includes all accessories), not otherwise specified.

28 TAC §134.203 (e) states in pertinent part, Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (1) the Division's fee guidelines; (2) a negotiated contract; or (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

Review of the Medicare DMEPOS fee schedule found no allowable for Code E0676 nor was an allowable found in the Texas Medicaid fee schedule.

The services in dispute are subject to provisions of 28 TAC §134.203 (f) which states fair and reasonable reimbursement shall be consistent with Labor Code §413.011, ensure similar procedures receive similar reimbursement and be based on nationally recognized published studies, published DWC medical dispute decisions or similar values assigned for services.

The requestor submitted the following documentation:

- An invoice showing "PlasmaFlow" in the amount of $2,100.00

The requestor does not discuss or explain how this information supports fair and reasonable reimbursement for the services in this dispute.

The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.

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 how the payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

Based on the above, DWC finds no additional reimbursement can be ordered.

Conclusion

For the reasons stated above, DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 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 DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.