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
Ortho Solutions of Kentuckian

Respondent Name
Travelers Indemnity Co

MFDR Tracking Number
M4-20-0704-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
November 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Given we provided the Vascutherm in accordance with their instruction in good faith, Travelers should pay for the equipment that was provided..."

Amount in Dispute: $2,079.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contents the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2019	E0676, E0671, E0673	$2,079.81	$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 defines fair and reasonable.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule
   - W3 – Additional payment made on appeal/reconsideration

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Is the insurance carrier's reasons for reduction of payment supported?
2. Is the insurance carrier's denial of payment supported?

Findings

1. The requestor is seeking additional reimbursement of the following codes for date of service February 26, 2019.
    - E0676 - Intermittent Limb Compression Device (Includes All Accessories), Not Otherwise Specified
    - E0671 - Segmental Gradient Pressure Pneumatic Appliance, Full Leg
    - E0673 - Segmental Gradient Pressure Pneumatic Appliance, Half Leg

    The insurance carrier reduced the health care provider's charge based on the DWC fee schedule. and denied the accessories as being bundled.

    28 TAC §134.203 (d)(1)(2) and (3) states the durable medical equipment described above is reimbursed at 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, or if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, or if neither Medicare or Medicaid has a fee, then calculate according to subsection (f) which states reimbursement shall be provided in accordance with §134.1 of this title.

    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 did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services nor do they discuss or explain how billed amount supports fair and reasonable reimbursement for the services in this dispute. Additionally, 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.

    Based on the above, DWC finds the requestor did not meet the requirements of 28 TAC §134.1. No additional reimbursement can be ordered.

2. The insurance carrier denied Code E0671 and E0673 described above as being included with the rental. 28 TAC 134.203 (b) requires Texas workers' compensation system participants to apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…

    The description of E0676 indicates all accessories are included. The insurance carrier's denial is supported. No additional reimbursement is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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	January 16, 2020 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 DWC 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.