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

Requestor Name
Duramed Inc

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-1819-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
March 30, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient had a contested case hearing on June 18, 2019 and it was determined that the patient sustained a compensable injury."

Amount in Dispute: $68.69

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office will maintain denial for charges in dispute for CARC code P15 as the medical records reviewed in this case do note provide supportive evidence of how this DME product is supported by ODG for the compensable injury."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 6, 2019	E0730	$68.69	$68.69

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted 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 Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P15 – Workers' compensation medical treatment guideline adjustment
   - 251 – The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim

Issues

1. Is the insurance carrier's reason for denial supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent submitted as their position statement, "…the medical records reviewed in this case do not provide supportive evidence of how this DME product is supported by ODG for the compensable injury."

   28 TAC Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

   28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

   Insufficient documentation was found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U.

   The insurance carrier's denial is not supported. The service in dispute will be reviewed based on applicable fee guideline.

2. 28 TAC 134.203 (d)(1) states the MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L is 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule.

   The DMEPOS fee schedule for the date of service is $54.95. This amount multiplied by 125% equals a MAR of $68.69

3. The allowable for the service in dispute $68.69. 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 $68.69.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $68.69, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____		April 24, 2020
Signature	Medical Fee Dispute Resolution Officer	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.