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
Duramed

Respondent Name
Starr Indemnity & Liability Co

MFDR Tracking Number
M4-20-2061-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note, the timely filing rule is overridden when the denials involve disputed issues on the claim per Rule 133.20. Also, per RULE 413.019 we expect INTEREST to be paid as well."

Amount in Dispute: $637.37

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached are EORs dated April 9, 2020 and May 4, 2020 recommending reimbursement of $467.68 for the July 29, 2019 date of service and $70.49 for the August 29, 2019 date of services.

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 29, 2019 August 29, 2019	DMEPOS	$637.37	$101.00

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 DMEPOS items.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Worker' compensation jurisdictional fee schedule adjustment

Issues

1. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of DMEPOS items that the insurance carrier reduced the payment amount based on the Texas Workers' Compensation Fee Schedule.

   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 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 applicable DMEPOS fee schedule found the following:

   - July 29, 2019 – E0730-RR allowed amount $54.95 x 125% = $68.69
   - July 29, 2019 - L0627 allowed amount $410.32 x 125% = $512.90. Per 28 TAC 134.203 (h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall **be the least** of the MAR amount or health care provider's usual and customary charge. The billed amount of $499.99 is the least amount thus, the allowed amount is $499.99
   - August 29, 2019 – E0730-NU allowed amount $54.95 x 125% = $68.69

   Total allowed amount $637.37. The insurance carrier paid $536.37. An additional payment in the amount of $101.00 is due to the requestor.

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 established payment is due. As a result, the amount ordered is $101.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $101.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 5, 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.