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 INC

Respondent Name
STARBUCKS CORPORATION

MFDR Tracking Number
M4-20-2409-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 4, 2020

Response Received by:
No response was submitted

REQUESTOR'S POSITION SUMMARY

"The above date of service was not paid and has been returned due to reason: 'Services not provided by network/primary care provider.' This is incorrect. The treating doctor referred the patient to the provider for durable medical equipment. Please see attached referral. All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment stilt needing to be paid."

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Starbucks Corporation is White Espey, PLLC. White Espey, PLLC acknowledged receipt of the copy of this medical fee dispute on June 9, 2020. 28 TAC §133.307(d)(1) states that if the DWC does not receive the response within 14-calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2019	E0730-RR	$68.69	$68.69

FINDINGS AND DECISION

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600 sets out the requirements of prior authorization.
4. Texas Insurance Code Chapter 1305 regulates certified workers' compensation health care networks.
5. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced.

6. The services in dispute were reduced / denied by the respondent with the following reason code(s):
   - RR - HOME-HOME/RENT/REQ RP/POST OP M
   - 230 - TREATMENT NOT AUTHORIZED.
   - 242 - SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS

Issues

1. Does this dispute contain a certified network issue?
2. Was preauthorization required for HCPCS Code E0730-RR rendered on August 21, 2019?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied the disputed services with denial reduction codes "242-Services not provided by network/primary care providers."

   The injured employee must be enrolled in the certified workers' compensation network and the certified workers' compensation network must be named on the explanation of benefits, per 28 TAC §133.240 (f) (15). Based on information maintained by the division, the injured employee is not enrolled in a worker's compensation health care network certified in accordance with Insurance Code Chapter 1305. The insurance carrier has never reported to the division that the injured employee was enrolled in certified workers' compensation health care network and has not provided any information to the DWC to support that the injured employee has been enrolled in such a network.

   28 TAC §133.240 (f) (15) requires that the insurance carrier shall include the "workers' compensation health care network name (if applicable)" on the paper form of an explanation of benefits. While the explanation of benefits does contain denial reason 242, its does not mention the health care network name on the paper form EOB, registered with the division as certified Texas workers' compensation health care networks established in accordance with Insurance Code Chapter 1305.

   Accordingly, based on the information presented to MFDR, the division finds that the insurance carrier has failed to meet the requirements of Rule §133.240 (f) (15). The insurance carrier thus failed to give plain language notice to the provider that a network was involved or that any special requirements were applicable and has therefore waived the right to assert that network provisions apply. The division concludes it has authority to review the fee issues in this dispute and will proceed to review them under applicable division rules and fee guidelines

2. The requestor is seeking medical fee dispute resolution in the amount of $68.69 for HCPCS Code E0730-RR, rendered on August 21, 2019.

   The respondent denied reimbursement for HCPC Code E0730-RR based upon reason code "230-Treatment not authorized."

   28 TAC §134.600(p)(8)(A-B) states "Non-emergency health care requiring preauthorization includes: 9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

   The insurance carrier did not submit a response to the DWC060 request. The information contained in the dispute did not contain information to support that the requestor billed for DME in excess of $500 billed charges per item. As a result, the DWC finds that the insurance carrier's denial reason is not supported, and the requestor is entitled to reimbursement for the disputed service.

3. The fee guidelines for the disputed service is found in 28 TAC §134.203 (d).

   28 TAC §134.203 (d) 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.

   The Medicare allowable for Code E0730-RR for Texas is $54.95. This amount multiplied by 125% equals a MAR of $68.69.

   The respondent paid $0.00. The requestor is therefore entitled to a total recommended amount of $68.69.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $68.69.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $68.69 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		August 25, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the 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 with the DWC. **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.