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
Federal Insurance Co

MFDR Tracking Number
M4-20-2775-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 27, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…authorization was given to bill for a 7 day rental of this device for this patient, totaling to $561.82."

Amount in Dispute: $481.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…per 28 Texas Labor Code 134.203(d)1) and CMS payment policies, the applicable fee schedule amount for rental is $64.21. This amount multiplied by 125% = $80.26.

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2020	E0217-RR	$481.56	$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 fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj
   - RA6 – Procedure Billing Restricted/Once per 30 days

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of Code E0217 – Water Circulating Heat Pad with Pump. Review of the requestors bill found number of units to be seven. The requestor indicates in their reconsideration request that the rental was for seven days.

28 TAC 134.203 (b) (1) states in pertinent part for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers.

Review of the applicable DMEPOS fee schedule at www.cms.gov, found the durable medical equipment item in dispute is classified as a capped rental item. Payment for capped rental items is limited to monthly rental.

The fee schedule amount for the date of service in dispute is $64.21. 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 shall be determined as 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. The MAR is $64.21 x 125% = $80.26. The insurance carrier paid $80.26 no additional payment is due.

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	August 21, 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.