TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Duramed

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-2776-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 27, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above date of service was not paid in FULL..."

Amount in Dispute: $62.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the DMEPOS manual does provide guidance that rental is 10% of the purchase price…".

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 26, 2020	E0730-RR	$62.92	$11.25

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 durable medical equipment.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical fee guideline
   - 196 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for the rental of durable medical equipment. The insurance carrier reduced the disputed services based on fee guidelines. 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."

   The Medicare Claims Processing Manual, Chapter 20, Section 30.1.2 found at www.cms.gov states, *In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, MACs pay 10 percent of the purchase price of the item for each of 2 months.*

   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 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 DMEPOS fee schedule found the purchase price for the disputed service to be $145.78. Ten percent of this amount is $14.58 multiplied by 125% equals a maximum allowable reimbursement of $18.23.

2. The MAR of the disputed service is $18.23. The insurance carrier paid $6.98. The balance of $11.25 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 $11.25.

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 $11.25, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 1, 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.