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
Ace American Insurance Co

MFDR Tracking Number
M4-21-0177-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 5, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed for a 30 day trial and only received partial payment for this service."

Amount in Dispute: $33.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2020	E0730-RR	$33.46	$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 guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4549 – This charge is being disallowed as having exceeded the DME rental timeframe of 2 months for tens units
   - 105 – Payment adjusted because rent/purchase guidelines were not met

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of durable medical equipment on July 7, 2020. The insurance carrier reduced the charges based on rent/purchase 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 the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers.

The applicable Medicare payment policy is found at www.cms.gov, the Claims Processing Manual, Chapter 20, Section 30.1.2 which 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) states in pertinent part, 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 DMEPOS fee schedule amount for the disputed date of service is $145.78. Ten percent of this amount is $14.58 which in turn is multiplied by 125% for the MAR of $18.22.

The total allowed amount is $18.22. This insurance carrier paid $36.44. No payment is recommended.

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

		November 5, 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 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.