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
Safety National Casualty Corp

MFDR Tracking Number
M4-21-0488-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 23, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The 2020 fee schedule allows for $80.26 to be reimbursed for code E0217-RR per unit. There were 7 units billed for this authorized treatment and did not receive full payment."

Amount in Dispute: $481.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Safety National Casual Corp is Flahive Ogden & Latson who was notified of this medical fee dispute on December 1, 20020. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division 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 §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2020	E0217 - RR	$481.63	$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:
   - 197 – Payment denied/reduced for absence of precertification/authorization

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 198 – Pre-authorization (certified treatment plan) applied to services.

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 inexpensive routinely purchased. Payment for this type of equipment is limited to rental or lump sum purchase.

Insufficient evidence was found to support rental is allowed on a daily basis rather than a monthly basis. 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	February 10, 2021 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.