TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
AMERICAN MEDICAL & REHAB CO.

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-1582-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
March 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 15, 2021 through September 15, 2021	E0118-RR x 3	$420.00	$336.00
	Total	$420.00	$336.00

Requestor's Position

"We have appealed multiple times and denied. Last denial was because the patient got a pair of crutches also. Per medical documentation, Dr. Cuda prescribed a knee walker to which we were authorized by Conventry [sic] to put out to the patient. We would not have put this piece of equipment out if were denied the authorization. Please consider all of the following and process for payment as authorized."

Amount in Dispute: $420.00

Respondent's Position

The Austin carrier representative for Texas Mutual Insurance Company is Texas Mutual Insurance Company. Texas Mutual Insurance Company was notified of this medical fee dispute on April 5, 2022. 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).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. 28 TAC §134.1 sets out the medical reimbursement policies.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- CAC-W3 – In accordance with TDI-DWC rule 134.804. this bill has been identified as a request for reconsideration or appeal.
- CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial reason supported?
2. Did the requestor submit documentation to support the requested payment amount?
3. Is the Requestor entitled to reimbursement?

Findings

1. Review of the submitted medical claim finds the code in dispute is E0118 which is defined as "Crutch substitute, lower leg platform, with or without wheels, each." The requestor appended modifier -RR to identify that the DME is a rental. The insurance carrier denied/reduced the DME with denial reduction code 225 (description provided above.)

   Review of the medical documentation submitted by the requestor supports the billing and documentation of the DME in dispute. As a result, the DWC finds that the insurance carrier's denial reason is not supported. The disputed service is therefore subject to review pursuant to 28 TAC §134.203(d)(3).

2. Durable medical equipment is subject to 28 TAC §134.203(d)(3) which states,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the applicable DMEPOS fee schedule finds no fee schedule amount for E0118 - RR. Review of the Texas Medicaid fee schedule finds no fee schedule amount for E0118 - RR. The service in dispute will be reviewed pursuant to 28 TAC §134.203(f) which states,

For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

3. The division concluded above that 28 TAC §134.1 applies and states,

Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

28 TAC §133.307(c)(2)(O), requires that the requestor provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds:

The requestor submitted additional documentation to support the fair and reasonable reimbursement of HCPCS Code E0118-RR. Review of the multiple copies of EOBs finds;

- The requestor submitted documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submitted documentation for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor supported that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

For the reasons stated, the DWC concludes that the requestor has supported reimbursement in the amount of $112.00 is a fair and reasonable reimbursement rate for the rental of the DME in dispute. For that reason, the requestor is entitled to reimbursement in the amount of $112.00 for date of service July 15, 2021, August 15, 2021, and September 15, 2021 for a total recommended amount of $336.00.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $336.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $336.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	June 23, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.