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
PEAK INTEGRATED HEALTHCARE

Respondent Name
NATIONAL UNITON FIRE INSURANCE CO.

MFDR Tracking Number
M4-22-2636-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 17, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2022	E0217-RR x 1 unit	$507.18	$0.00
	Total	$507.18	$0.00

Requestor's Position

"The charge does not exceed the fee scheduled value. Only 1 day ($ 84.53) of the 7-day rental was paid. The 2022 fee schedule allows for $591.71 to be reimbursed for code E0217RR. Please resubmit for adjudication."

Amount in Dispute: $507.18

Respondent's Position

"The provider billed $591.71 for CPT code E0217 a:nd has acknowledged that the carrier reimbursed the provider the amount of $84.53 for that CPT code. The provider is seeking additional reimbursement of$507.19. The provider claims that the carrier only reimbursed it for one day of a seven-day rental. However, the provider only billed for one day and thus, the provider was reimbursed in accordance with its bill... Based upon the provider's CMS-1500s, the provider is entitled to only one day rental. The provider has never corrected its billing to bill for an entire seven-day period. Accordingly, the carrier has reimbursed the provider in accordance with the provider's medical bill. Until and unless the provider changes the information on its CMS-1 SOOs, the provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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 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.

Denial Reasons

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

- 309 THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- P12 WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- NS600 Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. Is the requestor's position statement supported?
2. What is the applicable rule pertaining to reimbursement of DME?
3. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for HCPCS Code E0217-RR rendered May 24, 2022 in the amount of $507.18. The insurance carrier issued a payment in the amount of $84.53 and reduced the remaining charges with reduction codes indicated above.

   HCPCS Code E0217 is defined as "Water circulating heat pad with pump." The requestor appended modifier RR to identify that the DME service in dispute is a rental and not a purchase.

   The requestor in the position summary, states in pertinent part, "The charge does not exceed the fee scheduled value. Only 1 day ($ 84.53) of the ***7-day*** rental was paid. The 2022 fee schedule allows for $591.71 to be reimbursed for code E0217RR. Please resubmit for adjudication."

   The division finds that the copy of the CMS-1500 submitted for review, documents that the requestor billed 1 unit of HCPCs Code E0217-RR. The requestor is therefore entitled to reimbursement for the rental of E0217-RR pursuant to the applicable rules and fee guidelines.

2. 28 TAC 134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers."

   28 TAC §134.203(d) 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…"

Review of the DMEPOS fee schedule finds the following;

The 2022 Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted code is as follows:

- E0217 – RR x (1) unit. Review of the submitted medical bill supports one unit was billed not seven as indicated by the requestor.
- The Medicare allowable for one unit is $67.62 x 125% = MAR of $84.52
- The insurance carrier paid $84.53
- The requestor is therefore not entitled to additional reimbursement.

3. The DWC finds that the requestor has not established that additional reimbursement is allowed for HCPCs code E0217. Reimbursement is therefore not recommended.

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 not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services

Authorized Signature

		September 15, 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.