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
Standard Fire Insurance Co

MFDR Tracking Number
M4-24-0301-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
October 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 4, 2023	E0217	$422.62	$0.00
	Total	$422.62	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for Medical Fee Dispute Resolution (MFDR).

Amount in Dispute: $422.62

Respondent's Position

"The Carrier has reviewed the documentation and determined the Provider has been properly reimbursed for the 7-day rental. The Carrier contends the Provider is not entitled to additional reimbursement."
Response Submitted by: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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 the reimbursement guidelines for the disputed service.

Denial Reasons

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

- W3 – Bill is a reconsideration or appeal.
- 947 – Upheld, no additional allowance has been recommended.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What rule is applicable to reimbursement?

2. Is the requestor due additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of Code E0217 in the amount of $422.62 for date of service August 4, 2023. The insurance carrier reduced the payment based on workers' compensation fee schedule.

   DWC Rule 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…"
   The Medicare payment policy for DME is found at www.cms.gov, Medicare Claims Processing Manual, Chapter 20, Section 30.1 – Inexpensive or Other Routinely Purchase DME.

   For this type of equipment, A/B MACs (A), (B), or (HHE), and DME MACs pay for rental or

lump-sum purchases.

Review of the submitted medical bill indicates the "RR" modifier for rental however, the units indicated is "7". Review of the applicable Medicare payment policy does not indicate this item is paid on a daily rate. The applicable fee guideline calculation is shown below.

DWC Rule TAC §134.203 (d)(1) states in pertinent parts, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E. J, K, and L shall be determined as 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

The fee schedule amount for E0217-RR for Texas on the applicable date of service is $73.50. This amount multiplied by 125% = $91.88.

2. The total allowable for the service in dispute is $91.88. The insurance carrier paid $91.88. No additional payment is due.

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.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 3, 2023
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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.