



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Home Care Connect LLC

Respondent Name

Safety National Casualty Corp

MFDR Tracking Number

M4-25-2560-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 12, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 13, 2025 to January 27, 2025	E1399 ERMI	\$1945.00	\$0.00
January 13, 2025	S9999 Sales tax	\$180.09	\$0.00
Total		\$2125.09	\$0.00

Requester's Position

"On January 8, 2025, Corvel emailed us approving the service, billing codes and price. They also sent us a copy of the Utilization Review report. We provided services to the claimant in good faith, due to the approval of both coding and price, prior to accepting and rendering services..."

Amount in Dispute: \$2125.09

Respondent's Position

"As indicated above, the bill for DOS 1/13/2025 (to 01/27/25) was received 01/30/2025. ...the HCP's bill was for the 15-day rental of the "ERMI Ankle Flexionator Plus" device billed as E1399-RR. The HCP also billed for tax. DME is not taxable under TX WC. ...the Requestor is indicating that the adjuster agreed to payment in full and they supposedly included documentation to support that stance. However, the email attached to the MDFDR (and the Request for Reconsideration) from the adjuster simply indicates: *Please note the attached UR determination*

dated 1/2/2025. There is no agreement to pay in full and UR only addresses medical necessity. It is not a guarantee of payment.”

Response Submitted by: CorVel

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 out the billing requirements and fee guidelines for durable medical equipment.
3. [28 TAC §134.1](#) defines requirements of fair and reasonable .

Denial Reasons

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

- 16 – Svc lacks info needed or has billing error(s)
- P5 – Based on payor reasonable/customary fees
- RR – Rented equipment
- 524 – Recommended allowance per Insurer decision
- RM7 – Invalid code for CMS payment-resubmit w/valid code
- W3 – Appeal/Reconsideration

Issues

1. Did the requester support their position?
2. Did the respondent support their position statement?
3. What rule is applicable to reimbursement?

Findings

1. The requester is seeking additional payment for rental of durable medical equipment for date of service January 13 – 27, 2025.

The requestor states, “On January 8, 2025, Corvel emailed us approving the service, billing codes and price.”

The referenced email states, "Please note the attached UR determination dated 1/2/2025."

As the email referenced in the requester's position statement was only to indicate the utilization review for medical necessity was attached, the requester's position statement is not supported. The services in dispute will be reviewed per applicable fee guidelines.

2. The respondent submitted the following statement within their response to MFDR. "...our fair and reasonable payment is made on a monthly rental basis and based on the HCPCS code equivalent – in this case, E1816..." DWC Rule §134.203 (b)(1) 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;

DWC Rule §134.203 (a)(5) states, "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

Review of the Durable Medical Equipment Coding System (DMECS) from Palmetto GBA at www.palmettogba.com/pdac_dmecs/, found the ERMI Ankle Flexionator Plus is assigned HCPCS Code E1816.

The fee schedule category for code E1816 is Capped Rental Items. The long description is Static progressive stretch/patient actualized serial stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories.

Based on this review the respondent's position is supported. No additional payment is recommended.

3. The requester also included code S9999 – Sales Tax. This code is not valued in the DMEPOS fee schedule.

DWC Rule 28 TAC §134.203 (d) (2) states, "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."

DWC Rule 28 TAC §134.203 (f) 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).

DWC Rule 28 TAC §134.1 (f) states in pertinent part, " 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.

Review of the submitted documentation found the requester did not provide information required when requesting reimbursement of services not valued by Medicare or Medicaid that would be subject to fair and reasonable consideration. No payment is recommended for code S9999.

Conclusion

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

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

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

July 14, 2025
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 electrónico CompConnection@tdi.texas.gov.