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

Requester Name
Home Care Connect LLC

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-26-0378-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 16, 2025	E1399	$4057.68	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated September 3, 2025. An excerpt from their reconsideration states, "As noted in both our authorization request and bill, there is no specific HCPCS code assigned to this device, therefore, billed under the miscellaneous durable medical equipment, or E1399. As you will also see from the attachments, we received pricing approval for the device at a cost far exceeding the recommended reimbursement you have changed this to."

Amount in Dispute: $4,057.68

Respondent's Position

"The bill for DOS 06/16/2025 was received 07/24/2025 via Clearinghouse.. ...the HCP's bill was for the 30-day rental of the "*ERMI Shoulder Flexionator Plus*" device billed as E1399RR. ...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: *"Based on the attached UR certificate, I can provide the reasonable and necessary authorization as long as it's related to the compensable injury."* There is no agreement to pay in full."
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.

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
- RM7 – Invalid code for CMS payment-resubmit w/valid code
- W3 – Appeal/Reconsideration

Issues

1. Did the submit with correct HCPCS code?

Findings

1. The requester is seeking additional payment for rental of durable medical equipment for date of service June 16, 2025 through July 15, 2025.

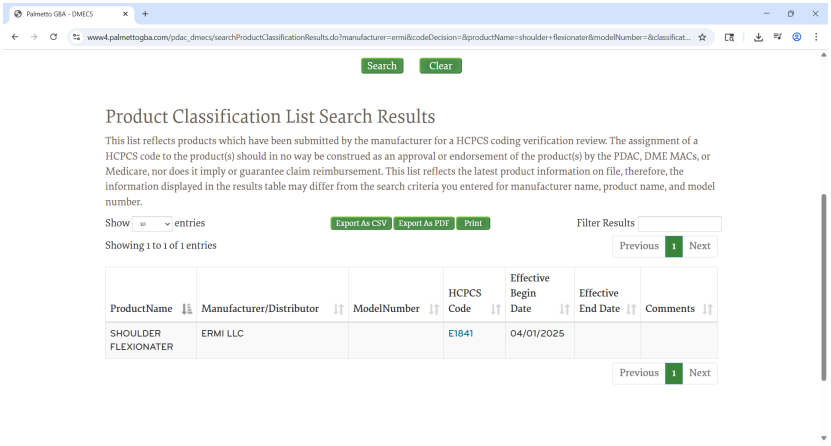
The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration in which they state, "…there is no specific HCPCS code assigned to this device, therefore, billed under the miscellaneous durable medical equipment, or E1399."

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 "RX" submitted with the documentation indicates, "ERMI Shoulder Flexionater Program." The Utilization Review indicates, ERMI Shoulder Flexionater approved for a 30 day rental.

Based on this review code E1399 is not the most appropriate code. As the requester did not submit the correct code of the disputed service, no payment is recommended.

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

_____		October 22, 2025
Signature	Medical Fee Dispute 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.