Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO MEDICAL SUPPLIES
1500 FREDERICKSBURG RD STE B
SAN ANTONIO TX 78201

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-4324-01

MFDR Date Received
JUNE 7, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier denied claim for no preauthorization. Each individual billed item does not exceed $500.00. See attached TDI-DWC rule. Carrier reviewed the total charge, which did exceed $500.00, and denied for lack of preauthorization. Request for reconsideration submitted timely but reviewed and denied as a duplicate claim and for lack of preauth. Payment for each item should be considered and paid."

Amount in Dispute: $567.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "(5) The requestor argues that DWC Rule 134.600 controls reimbursement in this case because of section (p)(9). Texas Mutual does not agree, (p)(12) does. Rule 134.600(p)(12) states, '…treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols…' require preauthorization. ODG does not address, for the low back, lumbar support belts or gel pressure mattresses. Absent preauthorization approval for these, no payment is due… (7) The tens/ems four lead unit (E0730) also required preauthorization under ODG because there a number of criteria that must be met before ODG recommends its usage. Texas Mutual never had the opportunity to prospectively review the use of this unit consistent with the ODG criteria. Absent preauthorization no payment is due. (8) The cervical collar support (L0190) required preauthorization under ODG because ODG does not recommend cervical support collars. The use of the support collar exceeds ODG, thus creating the need for preauthorization, which was not obtained. For these reasons Texas Mutual believes no additional payment is due."

Response Submitted by: Texas Mutual Insurance, 6210 E. Hwy 20, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2009	L0625-NU Lumbar Support Belt	$57.92	$0.00
September 29, 2009	E0185-NU Gel Pressure Mattress Pad	$387.92	$0.00
September 29, 2009	E0730-NU ENS Unit 4 Lead	$72.85	$0.00

September 29, 2009	L0190-NU Cervical Pillow	$49.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code $134.600 sets out the procedures for preauthorization of certain services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent.
   - 930 – Pre-authorization required. Reimbursement denied.
   - Denied in accordance with 134.600(p)(12) as the treatment/service is in excess of the Division's treatment guidelines as outlined in the disability management rules effective 5/1/07.
   - 18 – Duplicate claim/service.
   - 224 – Duplicate charge.

Issues

1. Did the DME items in dispute require preauthorization?
2. Was preauthorization obtained by the requestor?

Findings

1. The requestor in this dispute relies on 28 Texas Administrative Code §134.600(p)(9) which states, "all durable medical equipment in excess of $500 billed charges per item (either purchased or cumulative rental" as their basis for reimbursement. However, 134.600(p)(12) states, "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier." The DME items prescribed to the injured worker were as follows:
   - HCPCS code L0625-NU - Lumbar Support Belt, according to the ODG lumbar supports were, "Not recommended for prevention. Under study for treatment of nonspecific LBP. Recommended as an option for compression factures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Lumbar supports do not prevent LBP."; therefore, preauthorization was required.
   - HCPCS Code E0185-NU - Gel Pressure Mattress Pad was not addressed by the ODG, therefore preauthorization was required;
   - HCPCS Code E0730-NU - TENS Unit 4 Lead, according to ODG, "Not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration, including reductions in medication use." And " Acute: Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms." Therefore, preauthorization was required.
   - HCPCS Code L0190-NU - Cervical Pillow was not addressed by the ODG; therefore, preauthorization was required.
2. Review of the submitted documentation finds that the requestor did not seek preauthorization for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services..

Authorized Signature

		February 20, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.