



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

BRAZOS ANESTHESIOLOGY ASSOCIATES

**Respondent Name**

TEXAS A & M UNIVERSITY SYSTEM

**MFDR Tracking Number**

M4-10-4398-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

JUNE 16, 2010

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Our claim for 64416-59 for pain management after surgery was denied by the Texas A&M University System saying 'documentation received does not support use of an ON-Q pump based on the documentation submitted'. The surgeon, Dr Barry Veazey, ordered the pain block to be administered by us after shoulder surgery. We sent our pain block notes with the original claim."

**Amount in Dispute:** \$148.44

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Starr Comprehensive Solutions, Inc. maintains its position that the treatment exceeds the ODG, therefore, preauthorization was required."

**Response Submitted by:** Starr Comprehensive Solutions, Inc.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2010	CPT Code 64416-59	\$148.44	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
- 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
  - 197-Payment denied/reduced for absence of precertification/authorization.
  - 197-ODG does not support use of a ON-Q Pump based on the documentation submitted. See ODG Shoulder Chapter. Therefore, preauthorization is required.

- 150-Documentation received does not support the use of a On-Q Pain Pump for the work related injury that occurred on 03/23/2010.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

### **Issues**

Did the disputed service require preauthorization? Is the requestor entitled to reimbursement?

### **Findings**

According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason codes “197” and “150.”

Texas Administrative Code §134.600(p)(12) “Non-emergency health care requiring preauthorization includes: 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.”

28 Texas Administrative Code § 137.100(f) states “A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title.”

The requestor billed CPT code 64416-59 for the diagnosis 840.4 found in the shoulder.

According to the Shoulder Chapter of the Official Disability Guidelines (ODG), the disputed Postoperative pain pump is:

“Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This “pain pump” was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. There is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. ([Barber, 2002](#)) ([Quick, 2003](#)) ([Harvey, 2004](#)) ([Cigna, 2005](#)) ([Cho, 2007](#)) *Recent studies:* Three recent RCTs did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. ([Banerjee, 2008](#)) This study concluded that infusion pumps did not significantly reduce pain levels. ([Cicccone, 2008](#)) This study found no difference between interscalene block versus continuous subacromial infusion of a local anesthetic with regard to efficacy, complication rate, or cost. ([Webb, 2007](#)) *Adverse reactions:* A small case series (10 patients) concluded that use of intra-articular pain pump catheters eluting bupivacaine with epinephrine appear highly associated with postarthroscopic glenohumeral chondrolysis (PAGCL), and therefore intra-articular pain pump catheters should be avoided until further investigation. ([Hansen, 2007](#)) On the other hand, a retrospective study of 583 patients concluded that subacromial pain pumps used for arthroscopic shoulder procedures are safe in the short-term. ([Busfield, 2008](#)).”

Therefore, per the Shoulder Chapter of the ODG postoperative pain pumps are not a recommended treatment for the diagnosis 840.4. As a result, a preauthorization issue exists and reimbursement is not recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

04/11/2014  
\_\_\_\_\_  
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.**