



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

HCARE HURLEY BINSONS MED EQUIP

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Date Received

December 14, 2012

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-13-0979-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The doctor ordered an ice man for this patient. Patient received 5/03/12 and we were paid for this rental. The item continues to rent each month. When speaking to the patient, the patient stated he used it after his surgery and per his doctor during his physical therapy..."

Amount in Dispute: \$210.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant underwent shoulder surgery 3/25/12... The Shoulder treatment guideline, Official Disability Guideline (ODG), states the following in part: 'Recommendation as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use...' (Attachment 2). Because the delivery of the unit and its usage is outside the recommendation of ODG, preauthorization was required but none was obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 3, 2012 through December 3, 2012	E0218-RR x 7 days	\$210.00	\$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 §134.203 sets out the fee guideline for professional medical services.
- 28 Texas Administrative Code §134.600 sets out the preauthorization guidelines.
- 28 Texas Administrative Code §137.100 sets out the treatment guidelines.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC 193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
- CAC 197 – Precertification/authorization/notification absent.
- 762 – Denied in accordance with 134.600 (P)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
- 891 – No additional payment after reconsideration.
- 785 – Service rendered is integral to service requiring preauthorization. Pre-authorization not sought/approval not obtained for that service.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the disputed HCPCS code require pre-authorization in accordance with 28 Texas Administrative Code §134.600?
2. Is the disputed HCPCS code included in the treatment guidelines within 28 Texas Administrative Code §137.100?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Michigan to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code 134.600(p)(12), states, "(p) Non-emergency health care requiring preauthorization includes... (12) 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 insurance carrier..."

The requestor seeks reimbursement for HCPCS Code E0218-RR defined by the AMA CPT Code Book as "Water circulating cold pad with pump". The disputed service is not addressed in 28 Texas Administrative Code 134.600, as a result, the disputed charge is subject to the provisions of 28 Texas Administrative Code 137.100.

3. 28 Texas Administrative Code 137.100 (a) states, "(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp*, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning)."

28 Texas Administrative Code 137.100(d) states, "The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

- (1) the treatment(s) or service(s) were provided in a medical emergency; or
- (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

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 submitted insufficient documentation to support that the services in dispute were preauthorized in accordance with 28 Texas Administrative Code §134.600 or §137.300. As a result, reimbursement cannot be recommended for HCPCS code E0218.

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

Date

March 26, 2015

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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