



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

Ronald F Kahn MD

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-14-3178-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

February 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services rendered to (claimant) on 06/07/2012 were administered her in the physician's office therefore do not meet the criteria for which precert/preauth is required..."

Amount in Dispute: \$1,225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the disputed charges and determined pursuant to Rule 134.600 (p) which states, "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 carrier."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2012	Lumbar Facet Injections and SI Joint Injections	\$1,225.00	\$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 §134.600 sets out the guidelines for prospective and concurrent review of health care.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent
 - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor meet the Division requirements?

2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 197 – “Precertification/authorization/notification absent.” 28 Texas Labor Code §134.600 (12) states in pertinent part, “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.” Review of the submitted documentation finds:

- a. ODG guidelines Lumbar injections - Maximum procedures (2)
- b. ODG guidelines SI Injection – Not recommended

As the ODG guidelines were exceeded, prior authorization was required. Therefore, the carrier’s denial is supported.

2. Provisions of Rule 134.600 not met. No additional payment can be 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	March 2, 2015 Date
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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.