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
Memorial MRI and Diagnostic

Respondent Name
Chevron Corp

MFDR Tracking Number
M4-14-3315-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Brylowski review and provided assessment for the patient and concluded the patient has a right upper extremity (wrist and shoulder) sprain/strain. There would be additional physical therapy and possible diagnostic studies (per ODG) that might be necessary for these areas especially shoulder and neck. These findings make us aware that no authorization is necessary for the procedures (MRI shoulder, writ and cervical) which are being denied by the insurance carrier and due to being performed outside the time frame given by their authorization."

Amount in Dispute: $7,875.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is requesting reimbursement for three MRI's performed on 12/17/13. The bills were disputed due to "Payment denied/reduced for absence of, or exceeded, pre-certification/authorization." We continue to stand by this dispute and have attached three notices of non-certification by our pre-authorization department which supports the denial."

Response Submitted by: Broadspire, 8827 W Sam Houston Parkway N, Suite 110, Houston, TX 77040

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2013	73221 RT, 73221 RT 59, 72141	$7,875.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent
   - 910-049 – Payment denied/reduce for absence of, or exceeded, pre-certification/authorization

Issues

1. Did the requestor provide services that are subject to prior authorization requirements?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 910-049 – "Payment denied/reduce for absence of, or exceeded, pre-certification/authorization." Per 28 Texas Administrative Code §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 insurance carrier." Review of the submitted documentation finds;
    a. The carrier denied the treatment plan for the disputed services during a retrospective review.
    b. Review of ODG guidelines, Shoulder, finds - "Indications for imaging -- Magnetic resonance imaging (MRI): - Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs - Subacute shoulder pain, suspect instability/labral tear.
    c. Review of ODG guidelines, Wrist, finds: Indications for imaging -- Magnetic resonance imaging (MRI): - Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required - Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required - Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury) - chronic wrist pain, plain films normal, suspect soft tissue tumor - Chronic wrist pain, plain film normal or equivocal, suspect Kienböck's disease - Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008).
    d. Review of the ODG guidelines, Cervical Spine, finds: Indications for imaging -- MRI (magnetic resonance imaging):- Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present - Neck pain with radiculopathy if severe or progressive neurologic deficit - Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present - Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present - Chronic neck pain, radiographs show bone or disc margin destruction - Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" - Known cervical spine trauma: equivocal or positive plain films with neurological deficit - Upper back/thoracic spine trauma with neurological deficit.

    Based on the submitted documentation, the carrier's denial is supported as disputed services exceed ODG guidelines.
2. Requirements of Rule 134.600(p) (12) were not met. No additional reimbursement 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	February , 2015 Date

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.