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
Universal DME LLC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-3636-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 10/11/2013 we submitted our claim for payment to Texas Mutual in the amount of $495.00 via fax. On 11/18/2013 we received a denial for preauthorization absent. We have submitted the claim for payment on several occasions, with a copy of 134.600 guideline for preauthorization attached for review. We have submitted two appeals addressing this issue and later received denials for both for absent preauthorization….

Per the rule, 134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care reads as follows:

All durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

It is my understanding that a preauthorization is only required on items that are over $500 per line item, not the total billed amount. We should be paid for services rendered because we have submitted the appropriate needed for review."

Amount in Dispute: $495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 9/28/13. The requestor provided a lumbosacral brace to the claimant then billed Texas Mutual for this with code L0267. Texas Mutual reviewed the billing and attached documentation, ODG's treatment guideline for the Low Back – Lumbar & Thoracic, Rule 134.600(p)(12), and denied payment of the bill.

Review of the claim file shows the claimant had low back fusion surgery on 2/2/11. ODG states there is a lack of evidence supporting use of these devices after fusion surgery and they are under study. (Attachment) Rule 134.600(p)(12) says, 'treatment 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' require preauthorization.

The requestor argues the dollar amount involved is less than $500.00 and thus does not require preauthorization at (p)(9) of the same Rule. However, to pay for treatment outside the treatment guideline makes no sense and is not cost effective. That is why there is no dollar cutoff threshold listed in (p)(12).

No payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2013	LSO Brace	$495.00	$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 defines services that require preauthorization.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 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
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration

Issues

1. Does the requested service require preauthorization according to 28 Texas Administrative Code §134.600?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care **requiring** preauthorization includes: (9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental); (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 commissioner's adopted treatment guidelines and protocols at the time of service were 28 Texas Administrative Code §134.600 and the Official Disability Guidelines (ODG). (p)(9) only addresses DME services in excess of $500.00 per item. Therefore, these services require preauthorization regardless of the recommendations of the ODG. For DME services under $500.00, (p)(12) applies, as there are no other rules that address these services. Therefore, preauthorization is based on the recommendation of the ODG.

   The Low Back section of the ODG addresses post-operative (fusion) back braces by stating that they are under study and must be reviewed on a case by case basis to determine if there are special circumstances that may require their use. Therefore, the post-operative LSO brace requires preauthorization in accordance with 28 Texas Administrative Code §134.600.
2. The insurance carrier denied payment stating, "precertification/authorization/notification absent." 28 Texas Administrative Code §133.240 (b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title." Review of the submitted documentation does not support that preauthorization was requested or obtained. Therefore, the requestor is not entitled to reimbursement for the disputed charges.

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

	Laurie Garnes	January 8, 2015
Signature	Medical Fee Dispute Resolution Officer	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.