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 CO

MFDR Tracking Number
M4-15-0317-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 06/27/2014 we submitted our claim for payment to Texas Mutual in the amount of $1693.56 via fax…On 07/23/2014 we received a denial for preauthorization absent. We then submitted an appeal on 08/08/2014 for L0637 based on the original date of request since the denial was overturned. We then received another denial on 08/28/2014…The original date requested was 06/24/2014 and the denial was overturned for this."

Amount in Dispute: $1,603.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor received preauthorization for a back brace on 7/24/14. However, the requestor provided the brace and billed Texas Mutual for date of service 6/25/14. Because the requestor provided the brace on 6/25/14 without preauthorization, Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2014	HCPCS Code L0637-NU Lumbar Back Brace	$1,603.56	$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, effective July 1, 2012,requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-197-Precertification/authorization/notification absent.
   - 930-Pre-authorization required, reimbursement denied.
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 891-No additional payment after reconsideration.

Issues

Does a preauthorization issue exist? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed DME back brace code L0637 based upon a lack of preauthorization.

HCPCS code L0637 is defined as "Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise."

28 Texas Administrative Code §134.600(p)(9) states "all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)."

On July 14, 2014, the respondent gave preauthorization approval for the disputed back brace.

The requestor contends that payment is due because "The original date requested was 06/24/2014 and the denial was overturned for this."

The respondent states that "Because the requestor provided the brace on 6/25/14 without preauthorization, Texas Mutual declined to issue payment."

The Division finds that the submitted documentation does not support that on the disputed date of service the back brace, HCPCS code L0637, was preauthorized; therefore, a preauthorization issue exist in this dispute. As a result, no reimbursement is 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	04/10/2015 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.