



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

Respondent Name

XL Insurance America Inc

MFDR Tracking Number

M4-15-0513-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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: \$913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2014	E0673, E0675	\$913.00	\$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. 28 Texas Administrative Code §137.100 defines medical treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Payment adjusted for absence of precert/preauth
 - Comment – Per rule 134.600(p)(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.

Issues

1. Was pre-authorization required?

2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier’s Austin representative box, which was acknowledged, received on October 15, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. The carrier denied the submitted codes E0675 and E0673 as, 197 – “Payment adjusted for absence of precert/preauth.” 28 Texas Administrative Code §134.600(p)(12) states in pertinent part, “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.”

28 Texas Labor Code §137.100 (a) states in pertinent part, “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).”

Review of the Official Disability Guidelines (ODG) finds;

- a. Lymphadema pump (pneumatic compression device) “Recommend home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garment”

Review of the submitted medical bill finds the following;

- a. Place of service submitted was “22” or Outpatient hospital
- b. Submitted diagnosis codes were 844.9 – “Sprain and strain of unspecified site of knee and leg”.

Based on the above the Division finds prior authorization was required. The carrier’s denial is supported.

3. The requirements of Rule 134.600(p)(12) were not met as the reported diagnosis and place of service are not addressed in the ODG guidelines thus requiring prior authorization. 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	February 13, 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.