



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

M4-15-1643-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

FEBRUARY 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It has been brought to our attention that HCPCS code L0637 was denied due to precertification/authorization/notification absent. When in fact preauthorization was denied but then overturned at appeal."

Amount in Dispute: \$1,603.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor was given preauthorization on 11/25/14 to provide a back brace, code L0637, for the claimant. The requestor provided and billed Texas Mutual for the brace on 11/12/14, some 13 days prior to the authorization. Texas Mutual denied payment absent no preauthorization. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.600, effective July 1, 2012, requires preauthorization for specific treatments and services.
- 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 November 25, 2014, the respondent gave preauthorization approval for the disputed back brace.

The requestor contends that payment is due because “preauthorization was denied but then overturned at appeal.”

The respondent states that “The requestor provided and billed Texas Mutual for the brace on 11/12/14, some 13 days prior to the authorization. Texas Mutual denied payment absent no preauthorization. No payment is due.”

Based upon the submitted documentation, on November 12, 2014 the disputed back brace, HCPCS L0637, was not 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

Date

05/06/2015

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.