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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
American Hallmark Insurance Co

MFDR Tracking Number
M4-16-0067-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 10, 2015

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."

Amount in Dispute: $499.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Universal DME LLC was required by division rule to obtain preauthorization for HCPCS Code E0675 since the treatment and/or services proposed exceed or are not addressed by the commissioner's adopted treatment guidelines for the diagnosis code(s) billed. Moreover, the requestor has failed to provide sufficient evidence to substantiate that ODG criteria has been met for the use of a pneumatic compression device for treatment of the diagnoses billed. As such, per disability management rules under §137.100 the insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2015	E0675	$499.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 healthcare.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - ODG – Services exceed ODG guidelines; preauth is required
   - W3 – Appeal/Reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment adjusted for absence of precert/preauth" and ODG – "Services exceed ODG guidelines; preauth is required." 28 Texas Administrative Code §134.600(p)(12) requires that,

   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. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

   Review of the submitted information finds that;

   a. June 2015, ODG treatment guidelines state;

      I. Lymphedema pumps - 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 garments.

      II. Vasopneumatic devices (wound healing) - Recommended as an option to reduce edema after acute injury. Vasopneumatic devices apply pressure by special equipment to reduce swelling. They may be considered necessary to reduce edema after acute injury.

   b. Diagnosis submitted on medical claim, 844.9 – Sprain and strain of unspecified site of knee and leg and 836.0 - Tear of medial cartilage or meniscus of knee

   c. Place of service submitted on medical claim is "22" or Outpatient Hospital, not the patient's home

   d. Box 32 of medical claim indicate "Facility" as service location or where services were provided

   e. No request for prior authorization made for service in dispute.

   The insurance carrier's denial reason is supported. The ODG recommended guidelines were not met, the service in dispute was used while the patient was in the hospital and no prior authorization request was made. Additional reimbursement cannot be recommended.

2. As requirements of Division Rule 134.600 were not met no additional payment 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

		October , 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, 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 MFDR 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.