



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME LLC

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-0101-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted the appropriate paperwork for review."

Amount in Dispute: \$495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.600(p)(12) states that Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines. Texas Mutual has no record UNIVERSAL DME sought or was granted preauthorization for the lumbar support, code L0627. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2015	L0627	\$495.00	\$494.44

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 health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 197 – Precertification/authorization/notification absent
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly

Issues

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

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – “Precertification/authorization/notification absent.” 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. 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;

- Billed charge on submitted medical claim is \$495.00. Rule 134.600(p)(9) does not apply
- Review of May 2015, ODG – Lumbar supports, Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option).
- Submitted diagnosis codes - 724.0, Spinal stenosis, other than cervical, 722.10, Displacement of lumbar intervertebral disc without myelopathy
- “Plan” documented within respondent’s position statement. “RX for LSO brace for back support of mechanical back pain...” Rule 134.600(p)(12) does not apply

The insurance carrier’s denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (d) states,

The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

The service in dispute will be calculated as follows:

2015 DMEPOS TX Fee Schedule (L0627) = \$395.55 x 125% = \$494.44

3. The maximum allowable for the services in dispute is \$494.44. The carrier previously paid \$0.00. The remaining balance of \$494.44 is due to the requestor. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$494.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$494.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 2, 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, 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.