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
Federal Insurance Co

MFDR Tracking Number
M4-16-0369-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 13, 2015

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $491.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This item was not prescribed, no used, in accordance with the Official Disability Guidelines (ODGs). This item is allowed for home when a patient has a total knee replacement. The claimant did not have a total knee replacement. The item was not prescribed in accordance with its normal uses, and thus falls outside of the ODGs. Therefore, DWC Rule 134.600(p)(12) applies to this item as its use falls outside of the ODGS, and preauthorization was required. Because preauthorization was not obtained, payment is not owed."

Response Submitted by: Downs ♦ Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2015	E0935	$491.40	$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 §137.100 details concepts of disability management.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

4. 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
   - 18 – Duplicate claim/service

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 ODG – "Services exceed ODG guidelines" and 197 – Payment adjusted for absence of precert/preauth." 28 Texas Administrative Code §137.100 (a) - (d) states,

> (a) 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).
>
> (b) Information on how to obtain or inspect copies of the Division treatment guidelines may be found on the Division's website: www.tdi.state.tx.us.
>
> (c) Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
>
> (d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:
>
> (1) the treatment(s) or service(s) were provided in a medical emergency; or
> (2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

Review of the June 2015, ***ODG Guidelines***, finds,

> Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures:
>
> (1) Total knee arthroplasty (revision and primary)
>
> (2) Anterior cruciate ligament reconstruction (if inpatient care)
>
> (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005)
>
> For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight:
>
> (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with:
>
> (a) complex regional pain syndrome;
>
> (b) extensive arthrofibrosis or tendon fibrosis; or
>
> (c) physical, mental, or behavioral inability to participate in active physical therapy.

(2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies.

As the submitted Operative report states a "Right knee arthroscopy with partial medial and lateral menisci" was the procedure performed. The Division finds insufficient evidence to support the ODG treatment guidelines were met. Thus, per 28 Texas Administrative Code 134.600 (p) (12) which states,

> 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);

The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. Pursuant to Rule 137.100 and 134.600 additional payment cannot 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

		November , 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.