



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 CO

MFDR Tracking Number

M4-16-0382-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 07/13/2015 we submitted our claim for payment to Texas Mutual in the amount of \$8527.56 via fax #512-224-3889. On 08/24/2015 we received a denial with a partially paid claim in the amount of \$5398.10 and a denial for preauthorization absent on codes L0180 and L0120. On 09/01/2015 we sent an appeal via fax 512-224-3889. Out appeal was then denied again on 09/28/2015 for preauthorization absent. Per SUBCHAPTER G. PRESPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE. 134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. All durable medical equipment (DME) in excess of \$500 billed charges per item (either purchase or expected cumulative rental)."

Amount in Dispute: \$530.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 7/1/15. The requestor provided a cervical posterior collar (L0180) and a non-adjustable cervical foam collar (L0120) to go with it on 7/1/15. The operative report of the same date indicates the operation was a one level anterior cervical fusion at C6-7, which included instrumentation, specifically a "Life Spine kinetic plate 24mm" ODG states, with respect to post-operative fusion cervical collar, "Not recommended after single-level anterior cervical fusion with plate." (Attachment)

Absent preauthorization for providing devices specifically not recommended by ODG, Texas Mutual declined to issue payment."

Response Submitted by: TEXAS MUTUAL INSURANCE COMPANY

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 01, 2015, L0180-NU and L0120-NU, \$530.26, \$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 medical services, charges and payments for preauthorization, concurrent utilization review, and voluntary certification of health care.
3. 28 Texas Administrative Code §137.100 sets out the procedures for disability management on treatment guidelines.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
 - CAC-197 – Precertification/Authorization/Notification Absent
 - 762 – Denied in accordance with 134.600 (P)(12) Treatment/Service in excess of DWC Treatment Guidelines(ODG) per Disability Management Rules
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
 - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 350 – Bill has been identified as a request for reconsideration or appeal
 - 891- No additional payment after reconsideration

Issues

1. Did the services in dispute require preauthorization?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code CAC-P12 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment", CAC-197 – "Precertification/Authorization/Notification Absent", 762 – "Denied in accordance with 134.600 (P)(12) Treatment/Service in excess of DWC Treatment Guidelines(ODG) per Disability Management Rules", 790 – "This charge was reimbursed in accordance to the Texas Medical Fee Guideline", CAC-W3 – "– In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal", CAC-193 – "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly", 350 – "Bill has been identified as a request for reconsideration or appeal", 891 – "No additional payment after reconsideration."

28 Texas Administrative Code §134.600(p)(12) states "Non-emergency health care requiring preauthorization includes: 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 Administrative Code § 137.100(f) states "A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title."

The requestor billed with HCPCS codes L0180-NU and L0120-NU for the diagnoses 722.0, 723.1 and 723.4 found in the neck and upper back.

According to the Neck and Upper Back Chapter of the Official Disability Guidelines (ODG), HCPCS code L0180: "Not recommended after single-level anterior cervical fusion with plate. The use of a cervical brace does not improve the fusion rate or the clinical outcomes of patients undergoing single-level anterior

cervical fusion with plating. Plates limit motion between the graft and the vertebra in anterior cervical fusion. Still, the use of cervical collars after instrumented anterior cervical fusion is widely practiced. This RCT found there was also no statistically significant difference in any of the clinical measures between the Braced and Nonbraced group. The SF-36 Physical Component Summary, NDI, neck, and arm pain scores were similar in both groups at all time intervals and showed statistically significant improvement when compared with preoperative scores. There was no difference in the proportion of patients working at any time point. Independent radiologists reported higher rates of fusion in the Nonbraced group over all time intervals, but those were not statistically significant.” and L0120 “Not recommended for neck sprains. Patients diagnosed with WAD (whiplash associated disorders), and other related acute neck disorders may commence normal, pre-injury activities to facilitate recovery. Rest and immobilization using collars are less effective, and not recommended for treating whiplash patients. May be appropriate where post-operative and fracture indications exist.” Therefore, the disputed HCPCS codes L0180 and L0120, required preauthorization. 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

11/5/15

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.