



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

ANESTHESIA ALLIANCE OF DALLAS PA

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-16-0417-01

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Date Received**

OCTOBER 16, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The carrier denied payment of Code 99195-59 stating preauthorization not obtained for this procedure code. We sent a reconsideration request stating preauthorization is not required for this procedure. This code is billed for a PRP Blood Draw. PRP stands for platelet rich plasma. For certain procedures, the aesthesia provider draws blood from the patient... We have never requested preauthorization for this procedure, and this carrier has issued payment for other claims."

**Amount in Dispute:** \$200.42

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed code 99195, phlebotomy or blood draw. The phlebotomy was to obtain blood in order to extract the platelet rich protein (RPR) {sic} from it to be used by the surgeon in the lumbar spine surgery performed the same operative session. The Official Disability Guidelines (PDG) do not recommend the use of RPR [sic] for spinal surgery... For this reason Texas Mutual denied payment of the blood draw for a treatment that is outside of ODG and requires 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
March 18, 2015	CPT Code 99195-59	\$220.42	\$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**

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 procedures for preauthorization of services.
3. 28 Texas Administrative Code §13.100 sets out the procedures for treatment guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- 45 – Charge exceeds recommendations of treatment guidelines.
- 785 – Service rendered is integral to service requiring preauthorization, preauthorization not sought/approval not obtained for that service.

**Issues**

1. Did the requestor obtain preauthorization for one of the services rendered to the injured employee?
2. Is the requestor entitled to reimbursement?

**Findings**

1. ODG’s treatment guideline addresses Platelet-Rich Plasma (PRP) and does not recommended the procedure. The use of this CPT Code, since it exceeds ODG, would require preauthorization. Texas Administrative Code §134.600(p)(12) “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 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 CPT Code 99195 which is defined as “Phlebotomy, therapeutic (separate procedure)”.

According to the Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter of the Official Disability Guidelines (ODG), CPT Code 99195: “Not recommended. The results of platelet-rich plasma in spine surgery are limited and controversial. In this RCT, adding PRP in posterior lumbar fusion did not lead to a substantial improvement when compared with autologous bone only. The expense of using PRP cannot be justified until statistical significance can be read in a larger study. (Sys, 2012) A study of platelet-rich plasma on anterior fusion in spinal injuries concluded that this is not a clear advancement in spinal fusion in terms of a clinical benefit. (Hartmann, 2010);” therefore, the disputed CPT Code 99195, required preauthorization.

2. Because the requestor did not obtain preauthorization for the procedure billed, reimbursement is not supported.

**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	October 30, 2015 Date
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## ***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.**