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
Orthotexas Physicians & Surgeons

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-0566-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The DME billed for this patient falls under the $500.00 billed charges."

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 10, 2015. The insurance carrier did not submit a response for consideration in this review. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." Accordingly, this decision is based on the available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2015	L1833	$450.00	$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 health care.
3. 28 Texas Administrative Code §137.100 defines Division adopted treatment guidelines.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - B5 – Pymt Adj/Program guidelines not met or exceeded
   - 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." 28 Texas Administrative Code §134.600 (p) 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.

   28 Texas Administrative Code §137.100 (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).

   Review of the 2015 ODG Guidelines, Criteria for the use of knee braces:

   Prefabricated knee braces may be appropriate in patients with one of the following conditions:

   1. Knee instability
   2. Ligament insufficiency/deficiency
   3. Reconstructed ligament
   4. Articular defect repair
   5. Avascular necrosis
   6. Meniscal cartilage repair
   7. Painful failed total knee arthroplasty
   8. Painful high tibial osteotomy
   9. Painful unicompartmental osteoarthritis
   10. Tibial plateau fracture

   Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model:

   1. Abnormal limb contour, such as:
      a. Valgus [knock-kneed] limb
      b. Varus [bow-legged] limb
      c. Tibial varum
      d. Disproportionate thigh and calf (e.g., large thigh and small calf)
      e. Minimal muscle mass on which to suspend a brace
   2. Skin changes, such as:
      a. Excessive redundant soft skin
      b. Thin skin with risk of breakdown (e.g., chronic steroid use)
   3. Severe osteoarthritis (grade III or IV)

4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain)

5. Severe instability as noted on physical examination of knee

Review of the submitted diagnosis code on the submitted medical claim was 822.0 – "Fracture of patella". The insurance carrier's denial reason is supported as the stated diagnosis is not found in the above mentioned ODG criteria. Requirements of Rule 134.600(p)(12), not met. Additional reimbursement cannot be recommended.

2. 28 Texas Administrative Code 137.100 (d) states in pertinent part,

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.

Pursuant to the above, no additional payment can 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

		December 10, 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.