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
San Antonio Orthopaedic Institute

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-1039-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $177.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For steroid injections to the shoulder ODG recommends no more than three regardless if the diagnosis is adhesive capsulitis or impingement syndrome. The claimant has had three previous shoulder steroid injections… To provide the fourth injection, which is the subject of this dispute, the requestor required preauthorization. Texas Mutual has no record of a preauthorization request nor has the requestor provided any evidence preauthorization was obtained. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5, 2015	20160	$177.62	$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 sets out treatment guidelines.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 12 – Workers' compensation jurisdictional fee schedule adjustment
   - 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.

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 code762 – "Denied in accordance with 134.600 (p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules." 28 Texas Administrative Code §134.600 (p)(12) states in applicable part,

> 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(a) define the above referenced treatment guidelines as,

> 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 service in dispute (20610) finds the following:

- The CPT code definition of 20610 is - Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
- Review of the submitted "E-ProgNote" indicates, Plan: He has good strength, but still has pain. We did a Betadine prep, injected the right subacromial space with 3 cc of Marcaine, 3 cc of lidocaine, and 1 cc of Depo-Medrol with good relief."
- While code J1030 is not in dispute, review of the CPT code description finds; Methylprednisolone is a corticosteroid

Review of the above information finds the service in dispute was for a steroid injection. The 2015 Official Disability Guidelines for "steroid injections" finds:

> *Criteria for Steroid injections:*
> - *Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder;*
> - *Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months;*
> - *Pain interferes with functional activities (eg, pain with elevation is significantly limiting work);*
> - *Intended for short-term control of symptoms to resume conservative medical management;*
> - *Generally performed without fluoroscopic or ultrasound guidance;*
> - *Only one injection should be scheduled to start, rather than a series of three;*

- *A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;*
- *With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;*
- *The number of injections should be limited to three.*

The carrier states in their position statement that, "The claimant has had three previous shoulder steroid injections, i.e. 3/28/13, 1/2/14, and 10/2/14. To provide the fourth injection, which is the subject of this dispute, the requestor required preauthorization." Based on the review of the above information, the carrier's denial is supported.

2. 28 Texas Administrative Code §137.100 (d) states,

> 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.

The Division finds insufficient information to support the above mentioned requirements were met. Therefore, no additional reimbursement 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

		January 12, 2016
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.