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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
American Hallmark Insurance Company of Texas

MFDR Tracking Number
M4-16-2139-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
March 25, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We did not need authorization for this item per the rule 134.600 but as you will see in the attached documents, we did have an authorization from them. They also denied E0217 stating that it is not the right hcpcs code but indeed it is and that is what we were given prior authorization for #78299757 UMO 2."

Amount in Dispute: $1,466.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Respondent disagrees with both issues as detailed by the Requestor."

Response Submitted by: CorVel Healthcare Corporation, 10000 North Central Expressway, Suite 300, Dallas, TX 75231

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 15, 2015	E0673 -NU, E0675 -RR, E0217 -RR	$1,466.00	$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 requirements of prior authorization of medical services.
3. 28 Texas Administrative Code §133.20 sets out the requirements of medical bill submission.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 107 – Denied – qualifying svc not paid or identified
   - 193 – Original payment decision maintained

Issues

1. Is the carrier's denial supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the submitted code E0675 as, 197 – "Payment adjusted for absence of precert/preauth." 28 Texas Administrative Code §134.600(p)(12) states in pertinent part, "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 Labor Code §137.100 (a) states in pertinent part, "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 Official Disability Guidelines (ODG) finds;

   a. Lymphadema pump (pneumatic compression device) "Recommend home-use as an option for the treatment of lymphedema after a four-week trial of conservative medical management that includes exercise, elevation and compression garment"

   Review of the submitted medical bill finds the following;

   a. Place of service submitted was "22" or Outpatient hospital
   b. Submitted diagnosis codes were S40.011A – Contusion Right Shoulder Initial, M75.121 – Cmpl rot cuff tear/rupt RT shoulder, S43.401A – Uns sprain RT shoulder joint init.

   The requirements of Rule 134.600(p)(12) were not met as the reported diagnosis and place of service are not addressed in the ODG guidelines thus requiring prior authorization. No additional payment can be recommended.

   The carrier denied the submitted code E0673 as 107 – "Denied –qualifying svc not paid or identified." Review of the submitted code E0673 is described as "Segmental gradient pressure pneumatic appliance, half leg" the qualifying service being the compression device was not paid. Therefore, the carrier's denial of the supply is supported.
2. 28 Texas Administrative Code §133.20 (c) states,

   A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

   Review of the submitted documentation finds the following:
   - Submitted code in box 24D of medical claim form E0217 which is described as, "Water circ **heat** pad w/pump."
   - Authorization received is for "Cryo therapy unit rental x 7 days"

The carrier denied this service in dispute as 16 – "Svc lacks info needed or has billing error(s). As the submitted code description does not match the description of the authorized services, the carrier's denial is 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

		April 20, 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, 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.