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
Thomas Binzer M.D.

Respondent Name
Public WC Program

MFDR Tracking Number
M4-18-0568-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "She needs the brace because she is developing a malunion and nonunion of her right radial sytloid."

Amount in Dispute: $926.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was required for this DME because the billed charges per item was in excess of $500.00 billed charges per item (either purchase or expected cumulative rental.) Starr Comprehensive Solutions maintains its' position that preauthorization for the DME was required in accordance with rule 134.600(p)(9) and preauthorization was not obtained."

Response Submitted by: Starr Comprehensive Solutions, P.O. Box 801464, Houston, TX 77280

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 20, 2016	L3984	$926.25	$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 Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking $926.24 for code L3984 – "Upper extremity fracture orthotic, wrist, prefabricated, includes fitting and adjustment."

The insurance carrier denied disputed services with claim adjustment reason code 197 – "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §134.600 (p) (9) states in pertinent part,

> Non-emergency health care requiring preauthorization includes:
>
> all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental).

Review of the explanation of benefits found the "billed amount" was $926.25. As this amount exceeds five hundred dollars, prior authorization was required. However, insufficient evidence was found to support a prior authorization was obtained. The insurance carrier's denial reason is supported. Additional reimbursement cannot 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 4, 2018
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.