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
DURAMED, INC.

Respondent Name
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

MFDR Tracking Number
M4-19-0720-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
October 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per TWCC rule 134.600(p)(12) durable medical equipment requires preauthorization only when a single item exceeds $500."

Amount in Dispute: $405.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "DWC Rule 134.600(p)(12) requires all treatment that exceed or are not addressed by the commissioner's adopted treatment guidelines require preauthorization. The treatment in dispute, an upper extremity addition, excursion amplifier, and an unknown medication, are not addressed in the Official Disability Guidelines (ODG) for the Claimant's condition."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 26, 2018	Supplies and Durable Medical Equipment	$405.34	$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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
4. 28 Texas Administrative Code §137.100 sets out the division's treatment guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 5264 – Payment is denied–service not authorized.

- 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- OA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUNDLING OF SERVICES.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 216 – BASED ON THE FINDINGS OF A REVIEW ORGANIZATION.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not "reasonable or necessary". The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.

Issues

Was preauthorization required?

Findings

The insurance carrier denied disputed supplies and equipment with claim adjustment reason code:
197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION."

The respondent asserts:

> DWC Rule 134.600(p)(12) requires all treatment that exceed or are not addressed by the commissioner's adopted treatment guidelines require preauthorization. The treatment in dispute, an upper extremity addition, excursion amplifier, and an unknown medication, are not addressed in the Official Disability Guidelines (ODG) for the Claimant's condition. Therefore, they are not recommended by the ODGs and require preauthorization.

The requestor states: "Per TWCC rule 134.600(p)(12) durable medical equipment requires preauthorization only when a single item exceeds $500."

Rule §134.600(p)(9) requires preauthorization for all non-emergency "durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental)"

The three items in dispute include:

- A9150 (Nonprescription drugs) described in the submitted documentation as "Sombra."
- L6642 (Upper extremity addition, excursion amplifier, lever type) described as "Shoulder rehab kit."
- E0215 (Electric heat pad, moist) described in the records as "Heating pad."

Code A9150, "Sombra," is not durable medical equipment; as a nonprescription drug, it is a medical supply that is neither "durable" nor "equipment." Further, the word "Sombra" is not a medication, but rather a company that manufactures a number of products—including therapeutic gels and creams. The word "Sombra" is not by itself sufficient to describe or identify the product dispensed to the injured employee. The division finds the submitted information does not support this item as billed.

The two other items (heating pad and shoulder rehab kit) are durable medical equipment. None of the items exceed $500; as such, Rule §134.600(p)(9) does not require preauthorization for any of the disputed items. While Rule §134.600(p)(9) does not apply, preauthorization may still be required under Rule §134.600(p)(12).

Rule §134.600(p)(12) requires preauthorization for any non-emergency "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." No authorized treatment plan was presented for review.

The commissioner's treatment guidelines are adopted by reference in Rule §137.100(a), which requires health care providers to treat "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…"

Review of the division's treatment guidelines applicable for the date of service and to the injury (based on the listed diagnosis code) finds that none of the disputed items are specifically recommended or addressed. Because the disputed items are not addressed by the division's treatment guidelines and were not shown to be contained in a preauthorized treatment plan, all three items require preauthorization under Rule §134.600(p)(12).

Because preauthorization was required but not obtained, the insurance carrier is not liable for payment. The insurance carrier's denial reasons are supported. Additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	January 25, 2019
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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.