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
OrthoTexas Physician

Respondent Name
Federal Insurance Co

MFDR Tracking Number
M4-19- 3047-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
February 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On this date of service, claim denied stating "pre-auth required". Per Rule 134.600(p)(9) all DME in excess of $500 billed charges requires pre-auth. L1833 billed charges on this claim are $495.00, therefore no pre-auth required for this DME."

Amount in Dispute: $495.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The criteria for use of the knee orthosis, as defined by ODG, not met."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2018	L1833	$495.00	$495.00

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 requirements for prior authorization.
3. 28 Texas Administrative Code §137.100 sets out provision of the treatment guidelines
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Payment adjusted for absence of precert/preauth
   - 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. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement of $450.00 for code L1833 provided on February 22, 2018.

   The respondent states in their position statement, "The criteria for use of the knee orthosis, as defined by ODG, not met.

   28 Texas Administrative Code §137.100 (e) states,

   > An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

   28 Texas Administrative Code Part 1, Chapter 19, Subchapter U sets out the requirements for utilization review of health care provided under Texas workers' compensation insurance coverage.

   Applicable 28 TAC §19.2003 (b)(31) defines retrospective review as "A form of utilization review for health care services that have been provided to an injured employee."

   No documentation found to support that the insurance carrier retrospectively reviewed the reasonableness and medical necessity of the service in dispute pursuant to the minimal requirements of Chapter 19, subchapter U as required. The insurance carrier's position statement will not be considered in this review. The service in dispute will be reviewed per applicable DWC fee guideline.

2. 28 TAC 134.203 (d) states in pertinent part,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the DMEPOS fee schedule for the date of service February 22, 2018 finds an allowable of $551.74

   Per the provisions of the applicable DWC rule $551.74 x 125% = $689.68

   28 TAC 134.203 (h) states in pertinent part,

   > When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
   >
   > (1) MAR amount;
   >
   > (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount;

   The health care provider's usual and customary charge shown on the submitted medical bill was $495.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $495.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $495.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		March 7, 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, 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 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. **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.