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
Markel Insurance Co

MFDR Tracking Number
M4-20-0214-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment."

Amount in Dispute: $1,280.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has not accepted spondylolisthesis as part of the compensable injury… payment for the lumbar brace should not be owed."

Response Submitted by: Downs Stanford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 25, 2019	L0648	$1,280.91	$1,280.91

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 §133.240 sets out regulations for denials.
3. 28 Texas Administrative Code §134.600 sets out requirements of prior authorization.
4. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for durable medical equipment.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - C28 – Denied Per Carrier this treatment is not related to this workers comp claim
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration

Issues

1. Is this dispute subject to dismissal based on relatedness?
2. Is this dispute subject to dismissal based on medical necessity?
3. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking reimbursement for Code L0648 – Lumbar Sacral Brace. The insurance carrier denied the disputed service based on relatedness.

   28 TAC §133.240 (h) requires an insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (PLN11) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that the injury is not compensable.

   Review of the submitted documentation found insufficient evidence of the required notice. Insufficient evidence was found to dismiss this dispute based on relatedness.

2. The insurance carrier states, "…brace not for treatment of lumbar sprain/strain." Review of the submitted documentation found ReviewMed issued prior authorization on May 30, 2019, citing medical necessity of the requested item **was met** for the treatment of spondylolisthesis **and/or** documented instability.

   28 TAC 134.600 (c)(1)(B) states the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care when preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.

   Based on the above, the disputed service was found to be medically necessary and the requirements of Rule 134.600 (p)(9), all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental) were met. The service in dispute will be reviewed per applicable fee guideline.

3. 28 TAC 134.203 (d) states the maximum allowable reimbursement for the Code L0648 is 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 applicable DMEPOS fee schedule at https://www.dmepdac.com/ is $1,024.73 this amount multiplied by 125 per cent is $1,280.91. This amount is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has established payment is due. As a result, the amount ordered is $1,280.91.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable) and based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $1,280.91, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

		November 21, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.