MDR Tracking Number: M5-03-0319-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective September 1, 1993 and Commission Rule 133.305 titled Request for Medical Dispute Resolution, a dispute resolution review was conducted by the Medical Review Division regarding a medical payment dispute between the requestor and the respondent named above.

I. DISPUTE

1. **a.** Whether there should be reimbursement for ankle braces.

b. The request was submitted on 9-23-02.

II. EXHIBITS

1. **Requestor:**

a. TWCC 60 and Letter Requesting Dispute Resolution
b. HCFA-1450
c. EOB
d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. **Respondent:**

a. TWCC 60
b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.307(g)(3), the Division forwarded a request to the provider to submit two copies of additional documentation relevant to this dispute on 1-14-03. The specific documentation required is outlined in 133.307(g)(3)(A-F) and must be received by the Commission within 14 days of the requestor's receipt of this notice. The requestor did not submit the relevant documentation.

III. PARTIES' POSITIONS

1. Requestor:

"Patient was set up with medically necessary DME and insurance carrier refuses to pay 'fair and reasonable amounts as stated either in TWCC Medical Fee Guidelines or as per our geographical area (EOB's on file at our office from other insurance carriers to prove what 'fair and reasonable' is for our geographical area).

2. Respondent:

"Charges were paid at Fair and Reasonable rate per Ingenix."

IV. FINDINGS

1. Based on Commission Rule 133.305(d)(2), the only date of service eligible for review is 12-14-01.

2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
12-14-01	L4350 (x2)	$250.00 ea = $500.00	$76.32 ea = $152.64	F	DOP	Section 413.011(b) DME GR IX	The requestor did not submit documentation to support billed service per MFG, or that amount billed was fair and reasonable per Section 413.011(b).
Totals		$500.00	$152.64				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 19th day of February 2003.

Elizabeth Pickle, Medical Dispute Resolution Officer
Medical Review Division