AMENDED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-05-3871-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Insurance Company P O Box 40460 Houston, Texas 77240-0460 Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: WC949-711071

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/30/03	05/29/03	E1399	$100.00	$100.00
05/30/03	06/29/03	E1399	$100.00	$100.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "Attached is also documentation to show that this is the rate that Liberty Mutual normally and consistently reimburses for stimulator rental. Carrier's EOBs denied services as, "The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

PART V: AMENDED MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Medical Review Division's Findings and Decision of December 27, 2004, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.
This Amended Findings and Decision supercedes all previous decisions rendered in this matter.
The Medical Review Division rendered a Findings and Decision involving a Medical payment dispute. A decision was issued in favor of the Respondent. The Findings and Decision incorrectly quoted DME Ground Rules in the non-reimbursement of DME supplies, resulting in the issuance of this Notice of Withdrawal.

HCPCS code E1399 item should be billed at the usual and customary rate of the DME provider. Carrier shall reimburse at a fair and reasonable rate per the MFG DME IX (C).

Per Commission Rule 133.307(j)(f), the reimbursement for these items would be at a "fair and reasonable" rate. The requestor submitted product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D). The sample EOBs from the carrier does not prove that the Provider has accepted this reduced payment as fair and reasonable. On this basis, carrier's reimbursement is based on the rate for a different item and is not fair and reasonable.
Therefore, based on this information additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

					Total Left Column:		$0.00
					Total Amount Due:		$200.00

PART VII: COMMISSION AMENDED DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$200.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of the Order.

Ordered by:

	Michael Bucklin	02/08/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Amended Decision is deemed received by you five days after it was mailed and the first working day after the date the Amended Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Amended Decision should be attached to the request.

The party appealing the Division's Amended Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

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

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Amended Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____