AMENDED MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-05-5086-01 **(Previously M4-04-7978-01)** TWCC No.: Injured Employee's Name:
Respondent's Name and Address Insurance Company of the State of PA C/O Dean Pappas & Associates P O Box 40460 Houston, Texas 77240-0460 Box 29	Date of Injury: Employer's Name: Continental Airlines, Inc. Insurance Carrier's No.: 001534074765WC01

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**			
07/08/03	**08/07/03**	**E1399**	**$100.00**	**$100.00**
08/08/03	**09/07/03**	**E1399**	**$100.00**	**$100.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We have provided product information and pricing documentation along with the prescription from the patient's doctor of record. We are also including copies of EOBs from carriers who are paying at our price list."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Carrier's EOBs denied services as, "C-FHN contract status indicator. Non-contracted provider."

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

The Medical Review Division's Findings and Decision of February 04, 2005, was issued in error and subsequently withdrawn by the Medical Review Division.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 denied reimbursement per the denial listed on the EOB for non-contracted provider of DME supplies, resulting in the issuance of this Notice of Withdrawal.

The only denial listed is for non-contracted provider and no other denials are noted in the case file. Therefore, since these charges are not eligible for contract reduction, this dispute will be reviewed per DME ground rules.

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	04/28/05
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, 7551 Metro Center Drive, Suite 100, 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: _____