Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address:	
OXYMED, INC P. O. Box 972557 Dallas, Texas 75397-2557	MDR Tracking No.: M4-04-5225-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: INSURANCE COMPANY OF THE STATE OF PA C/o Flahive Ogden & Latson Rep Box # 19	Date of Injury: Employer's Name: Laidlaw International, Inc. Insurance Carrier's No.: 023050000036090001

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"We feel that we are due full and total amount for the equipment provided to this patient. The carrier has incorrectly reviewed this claim and has paid this claim at a reduced rate. We have provided the carrier with examples of payments. Items are billed at a fair & reasonable rate according to the Commission Rules and Fee Guidelines. These claim items were submitted based on the 1991 Fee Guidelines and should have been paid accordingly. We have provided the carrier with examples of payments in full to substantiate the amount billed on the HCFA-1500 and are now requesting the remaining amount to be paid in **Full** with accrued **interest.** …"

Principle Documentation:

1. Requestor's position statement
2. TWCC 60/Table of Disputed Services
3. CMS 1500
4. Explanation of Benefits
5. Redacted Explanation of Benefits

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Carrier reduced the usual and customary billing of the provider (HCP) of $392.00 to a fair and reasonable $155.71 there being no MAR for this device, leaving $236.29 in dispute. Additionally, the HCP provided no justification for their position, that they were not reimbursed in a fair and reasonable manner…"

Principle Documentation:

1. Respondent's position statement
2. TWCC 60/Table of Disputed Services
3. Explanation of Benefits

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
04/22/03	F	L3670 (Purchase of Post-Op Brace)	1	$00.00
TOTAL DUE				$00.00

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

1. Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.201 titled (Medical Fee Guideline For Medical Treatments and Services Provided Under the Texas Worker's Compensation Act) effective April 1, 1996, sets out reimbursement guidelines.

This dispute relates to whether additional payment for DME code L3670 (Purchase of Post-Op Fracture Brace). The insurance carrier paid $155.71 based upon "F—Fee Guideline MAR Reduction."

Although the requestor did submit a brief description of the item, the requestor did not submit an invoice that would indicate the unit price to include tax and shipping charge.

Per DME Ground Rule (IV), DME items do not have a MAR, and will be reimbursed at fair and reasonable.

Section 413.011(b) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded to this subtitle in establishing the fee guidelines."

The requestor has the burden of proof to support that the amount sought is fair and reasonable. Redacted EOB's do not support criteria of Section 413.011(b) to support additional payment. Therefore, additional payment is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec.§ 413.011(a-d)
28 Texas Administrative Code Sec.§ 134.1
28 Texas Administrative Code Sec.§ 413.011(b)
1996 Medical Fee Guideline:
DME Ground Rule IV

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of the Texas Labor Code, Sec. 413.031, the Division has determined that the requestor is **not** entitled to additional reimbursement.

Ordered by:

		12/13/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

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