

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: () Health Care Provider (x) Injured Employee	() Insurance Carrier
Requestor's Name and Address:	MDR Tracking No.: M4-05-B420-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: El Paso I.S.D.	Date of Injury:
C/o Harris & Harris	Employer's Name: El Paso I.S.D.
Rep Box #: 42	Insurance Carrier's No.: ES102986

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's position summary states in part, "...I am writing this letter in reference to the above as there has been a refusal to reimburse funds on an orthopedic bed. In the denial, it states that 'the claimant is suffering from a pre-existing condition.' However, enclosed is a copy of the MMI done by Dr. Charles Cavaretta on 7/5/05. In his report, on page 6, it states; 'it is quite clear that his examinee did not have this discomfort prior to his injuries, in that they have persisted since that time.' This statement supports that this is not 'pre-existing' as has been concluded. Also enclosed is a copy of the letter by my treating doctor that supports the medical necessity for an orthopedic bed..." Principle Documentation:

- 1. Requestor's position summary
- 2. Perscription

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent did not submit a response.

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)
04/11/05	62B	DME – Therapeutic Bed	1	\$00.00
TOTAL DUE				\$00.00

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

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, sets out reimbursement guidelines.

1. On April 11, 2005 the Requestor purchased a Tempur-Pedic bed in the amount of \$1,6,79.98. On 12/21/2005 the Respondent denied the durable medical equipment (DME) as "62B – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Prior Authorization not obtained." Per Rule 134.600(h)(11) all DME in excess of \$500 per item requires preauthorization. The Requestor did not obtain preauthorization before the purchase of the bed; therefore, reimbursement 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. §134.201
- 28 Texas Administrative Code Sec. §134.202
- 29 Texas Administrative Code Sec. §134.600(h)(11)

PART VII: DIVISION DECISION AND ORDER

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

Decision by:

PA

	Marguerite Foster	April 7, 2006			
Authorized Signature	Typed Name	Date of Order			
ART 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.

April 7 2006