Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 11/19/01.
   b. The request was received on 03/05/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Position Statement located on the Table of Disputed Services
   b. HCFAs-1500
   c. TWCC 62 forms
   d. EOBs from other insurance carriers
   e. Medical documentation
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No Response Found in the Commission File

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the requestor's 14 day response on 06/26/02. The Respondent did not submit a response to the request. The "No Additional Information Found In Case File" sheet is reflected in Exhibit II of the Commission's Case File.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Table of Disputed Services
   "We feel that we should be reimbursed at the full billed amount found on the HCFA 1500. The Insurance Company is stating we were paid at a fair and reasonable rate and we wer [sic] NOT. We have resubmitted these claims with examples of payments in full from other carriers for the same service in this geographical area. We are now requesting additional payments with interest on all partially paid claims."

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/19/02.

2. The carrier denied the billed charges by denial code, "M – No MAR, REDUCED TO FAIR AND REASONABLE" and "G – UNBUNDLING INCLUDED IN ANOTHER BILLED PROCEDURE."

3. Per the provider's TWCC-60, the amount billed is $714.00; the amount paid is $233.53; the amount in dispute is $480.47.

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

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
01/19/01	E1399 Electrodes E1399 Back brace L1499 Unlisted procedure Spine - Insert for brace E1399NU Lumbar pillow E1399 Cervical pillow	$85.00 $215.00 $50.00 $239.99 $125.00	$20.87 $172.00 $0.00 $20.33 $20.33	M M G M M	DOP	Rule 133.307 (g) (3) (D), (E); HCPCS code ; MFG DME GR (IV); MFG DME (IX)	The reimbursement data evidence, in the form of EOBs from other carriers, submitted by the provider proved to be insufficient to meet the criteria of Rule 133.307 (g) (3) (D) which states, "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1 of this title…." The provider submitted thirteen EOBs from other carriers. Two of the EOBs were not redacted of the patient's name per Rule 133.307 (g) (3) (E). None of the EOBs submitted identified the disputed DME items, except for the two, which were the unredacted EOBs. Each EOB submitted from the other insurance carriers used the HCPCS codes E1399 and L1499 with reimbursement amounts. However, there were no corresponding HCFAs from the other carriers identifying that the DME item on the submitted EOBs were the same as the DME billed. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. Without identification of the HCPCS codes E1399 and L1499 in dispute on the example EOBs, the provider failed to submit sufficient documentation to establish that the payments made by the carrier were not fair and reasonable. The HCPCS code E1399-NU is also denied reimbursement because the "NU" modifier is not recognized in the Commission's '96 MFG. Therefore, the MDR is unable to determine proper reimbursement for this DME item. As far as HCPCS code L1499, "insert" for brace, the provider's prescription dated 11/08/01 does not include the insert. The prescription prescribes "BACK BRACE" only. Therefore, it is the MDR determination that the "insert" for the back brace is global to the back brace. **No** additional reimbursement is recommended.
Totals		$714.00	$233.33				The Requestor **is not** entitled to reimbursement.

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

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm