



MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity and Fee Dispute

PART I: GENERAL INFORMATION

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|---|---------------------------------|
| Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier | |
| Requestor's Name and Address: | MDR Tracking No.: M5-05-3087-01 |
| RS Medical P.O. Box 872650 Vancouver, WA 98687-2650 | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: Ace American Insurance Company, Box 15 | Date of Injury: |
| | Employer's Name: |
| | Insurance Carrier's No.: |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Documents included TWCC 60 form, Explanations of Benefits and CMS 1500's. "There is no established fee schedule for this device. Med Nec was established by authorization from the Preauth Dept on 12-15-04. Auth # PH174817A."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

The Respondent has submitted no position summary.

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

| Date(s) of Service | CPT Code(s) or Description | Medically Necessary? | Additional Amount Due (if any) |
|--------------------|------------------------------------|---|--------------------------------|
| 12-6-04 | E1399 – RS4i Stimulator for lumbar | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | \$2,495.00 |
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PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

These services were preauthorized and should not have been denied by the carrier for medical necessity. Therefore, the file contains unresolved medical fee issues only. The Division shall proceed to resolve the medical fee dispute in accordance with Rule 133.307.

Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Requestor when billing for services for which the Commission has not established a maximum allowable reimbursement. Per Rule 133.307(g)(3)(D), the Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided sample EOBs and other evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers.

In accordance with Rule 134.600 (h) (4), the requestor provided a copy of the preauthorization letter dated 12-15-04 for the purchase of an RS4i Stimulator. The carrier denied these sessions for unnecessary medical treatment. Rule 133.301 (a) states "the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatments (s) and/or service (s) for which the health care provider has obtained preauthorization under Chapter 134 of this title." Therefore, reimbursement is recommended in the amount of \$2,495.00 in accordance with Rule 134.600 (b)(1)(B).

Texas Labor Code 413.011 (d) and Rule 133.304 (i) (1-4) place certain requirements on the Carrier when reducing the services for which the Commission has not established a maximum allowable reimbursement. The Carrier is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The Carrier in this case has not provided a methodology as required by the rule.

On 8-19-05 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 133.307 and Sec. 133.301.

PART VII: DIVISION DECISION

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 entitled to additional reimbursement in the amount of \$2,495.00. 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 30-days of receipt of this Order.

Findings and Decision and Order by:

Donna Auby

9-16-05

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.