DOCKET NO. 453-03-2104.M4
MDR TRACKING NO. M4-02-4319-01

AMERICAN HOME ASSURANCE COMPANY, PETITIONER	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
OXYMED, INC., RESPONDENT	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

American Home Assurance Company (the Carrier), appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division (MRD) which granted reimbursement totaling $535 for a Lumbar Sacral Orthosis (LSO) back brace and accompanying pad provided to workers' compensation claimant ___The Carrier had denied reimbursement to Oxymed, Inc. (the Provider), claiming that the Provider should have requested preauthorization. The Carrier also contended the Provider failed to include an invoice showing its cost for the items. This decision finds that the Carrier must reimburse the Provider for the disputed items.

I. JURISDICTION, NOTICE, AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction, notice, or venue. Therefore, those issues are addressed in the findings of fact and conclusions of law without further discussion here.

The hearing in this matter convened on May 14, 2003, in Austin, Texas, with Administrative Law Judge (ALJ) Kerry D. Sullivan presiding. The Carrier was represented by Steven Tipton. The Provider was represented by Peter Rogers. The Commission did not participate in the hearing.

II. EVIDENCE AND BASIS FOR DECISION

There is no dispute regarding the medical necessity of the requested brace and pad. The Carrier's first basis for denial was that it needed the Respondent's invoices in order to appropriately review the charges. At hearing, the Carrier interpreted this denial as being based on the Respondent's failure to establish the fair and reasonable reimbursement for the items. Assuming this liberal reconstruction is appropriate, the ALJ notes that the Carrier presented no evidence that the charged amounts were not fair and reasonable. Because the Carrier bore the burden of proof in this proceeding,[1] this contention fails. In any event, the charges were those allowed under the 1991 Medical Fee Guideline. While the subsequent 1996 Guideline did not identify the appropriate level of reimbursement, the evidence indicated the cost of such devices has remained about the same since 1991.

The ALJ also concludes that the Provider was not required to secure preathorization for the brace and pad. The pertinent section of the preauthorization rule states that preauthorization is required for "all durable medical equipment (DME) in excess of $500 per item. . . ."[2]

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[1] 28 TAC §§ 148.21(h) and (i); 1 TAC § 155.41.

[2] 28 TAC § 134.600(h)(11).

The Carrier would define "item" in accordance with two previous SOAH cases as the sum of the cost of all components necessary to make the device in question a "functional piece of medical equipment (e.g., one capable of delivering a health care service)."[3] In this case, the Provider charged $450 for the brace itself and another $85 for the pad, for a total of $535. The uncontroverted evidence also indicates that the brace is never purchased without a pad, although replacement pads are sometimes purchased without a brace.

The Provider points out, however, that the DME Ground Rule instructs that "DME supplies shall be itemized and billed under the appropriate HCPCS codes."[4] This language appears to indicate the regulations view as an "item" anything appropriately billed to its own HCPCS code. To "itemize" is, after all, simply "to place or include on a list of items."[5] The Provider's approach is also consistent with the general dictionary definition of "item" as "a single article or unit in a collection, enumeration, or series."[6] Under these circumstances, the ALJ concurs with the Provider that the current regulations envision that each HCPCS code that the Provider appropriately bills should be considered as a separate "item" in terms of assessing the applicability of the Preauthorization rule. Accepting this approach honors the apparent intent of the Commission and establishes objective criteria for applying the rule.[7]

There are in fact separate HCPCS codes for the brace itself (L0565) and the replaceable pad (L0960), and there has been no assertion that the bills were improperly coded. Therefore, the cost of the brace and pad must be considered separately, and neither item falls within the $500 threshold of the Preauthorization rule.

Based on the foregoing, the Carrier's petition is denied and the Carrier is required to reimburse the Provider $535 for the disputed items.

III. FINDINGS OF FACT

1. On___. (Claimant) suffered a back injury compensable under the Texas Workers' Compensation Act.

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[3] SOAH Docket No. 453-02-3127 (Decision and Order dated October 10, 2002); see also SOAH Docket No. 453-03-0924.M5 (Decision and Order dated February 6, 2003).

[4] Medical Fee Guideline p. 254, Section VIII.

[5] American Heritage Dictionary (4th ed. 2000). The pads are presumably appropriately categorized as DME supplies.

[6] *Id.*

[7] Additionally, as long as the Provider is limited to items that are appropriately given their own HCPCS code, their is no real danger that it would be allowed to subvert the intent of the $500 preauthorization requirement. Instead, it appears the Commission chose the "per item" language of the rule in order to accommodate this very practice.

2. At the time of Claimant's compensable injury, American Home Assurance Company (Carrier), was the workers' compensation insurer for the Claimant's employer.

3. On February 12, 2002, Oxymed, Inc. (Provider), provided the Claimant with a Lumbar Sacral Orthosis (LSO) back brace and accompanying pad.

4. The Provider billed the Carrier $450 for the LSO back brace and $85 for the accompanying replaceable pad.

5. The Provider did not request preauthorization of the LSO back brace and pad.

6. The Carrier denied reimbursement on the basis that the Provider should have requested preauthorization and also failed to provide an invoice showing its cost for the items.

7. The Provider requested medical dispute resolution after the Carrier denied its request for reimbursement for the LSO back brace and pad.

8. The Carrier appealed the decision of the Texas Workers' Compensation Commission's (Commission) Medical Review Division, which ordered the Carrier to reimburse the Provider $450 for the LSO back brace and $85 for the pad.

9. Pursuant to the notice of hearing sent by the Commission's Staff, all parties appeared and were represented at the hearing held in this matter on May 14, 2003.

10. The Provider billed for the disputed services at the rate approved in the Commission's 1991 Medical Fee Guideline.

11. The Carrier failed to establish that the Provider's charges were not fair and reasonable.

12. The LSO back brace is appropriately billed under HCPCS Code L0565; the accompanying pad is appropriately billed under HCPCS Code L0960.

IV. CONCLUSIONS OF LAW

1 The Texas Workers' Compensation Commission (Commission) has jurisdiction related to this matter pursuant to the Texas Workers' Compensation Act (Act), TEX. LABOR CODE ANN. § 413.031.

2 The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to § 413.031(d) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3 The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 and the Commission's rules, 28 TEX. ADMIN. CODE (TAC) § 133.305(g).

4 Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052.

5 The Petitioner has the burden of proof in this proceeding. 28 TAC §§ 148.21(h) and (i); 1 TAC § 155.41.

6. Pursuant to the Act, an employee who has sustained a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. TEX. LAB. CODE ANN. § 408.021(a).

7. Health care includes all reasonable and necessary medical services, including a medical appliance or supply. TEX. LAB. CODE ANN. §401.011(19)(A). A medical benefit is a payment for health care reasonably required by the nature of the compensable injury. TEX. LAB. CODE ANN. § 401.011(31).

8. For a carrier to be liable for reimbursement, the provider must obtain preauthorization for all durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental). 28 TAC § 134.600(h)(11).

9. Each HCPCS code that the Provider appropriately bills should be considered as a separate "item" in terms of assessing the applicability of the Preauthorization rule.

10. Preauthorization was not required for the Lumbar Sacral Orthosis back brace and accompanying pad because they constitute two separate items.

11. The Petitioner is obligated to reimburse the Provider for the Lumbar Sacral Orthosis back brace and accompanying pad.

ORDER

IT IS ORDERED that Texas Home Assurance Company pay Oxymed, Inc., $535 for the LSO back brace and accompanying pad provided to workers' compensation claimant ____

SIGNED this 20th day of May, 2003.

KERRY D. SULLIVAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS