**STATE OFFICE OF ADMINISTRATIVE HEARINGS**
**300 West 15th Street, Ste. 502**
**Austin, TX 78701**

**Docket No. 453-02-3775.M4**
**[MDR TRACKING NO. M4-02-1902-01]**

| | | |
|---|---|---|
| **OXYMED, INC.,** | § | **BEFORE THE STATE OFFICE** |
| ***Petitioner*** | § | |
| | § | |
| **VS.** | § | **OF** |
| | § | |
| **CAMDEN FIRE INSURANCE COMPANY,** | § | |
| ***Respondent*** | § | **ADMINISTRATIVE HEARINGS** |

## DECISION AND ORDER

### I. Summary

OxyMed, Inc. (Provider) challenges a decision of the Texas Workers' Compensation Commission's Medical Review Division (MRD) denying it additional reimbursement of $383.50 for durable medical equipment (DME) provided to an injured worker. Camden Fire Insurance Company (Carrier) denied full reimbursement based on its conclusion that the billed amount was not fair and reasonable. The Administrative Law Judge (ALJ) concludes Provider met its burden of proof and is entitled to full reimbursement.

A hearing convened and closed before ALJ Gary Elkins on October 16, 2002. Attorney Peter Rogers appeared on behalf of Provider. Attorney Jeffrey Cunningham appeared on behalf of Carrier.

### II. Jurisdiction and Notice

Neither jurisdiction nor notice were contested; they are addressed only in the Findings of Fact and Conclusions of Law.

## III. Discussion

### A. Evidence and Argument

Provider seeks reimbursement of $383.50, the difference between the amount it billed ($865.00) for four DME items and the amount it was reimbursed by Carrier ($481.50) for the items. The items included a back brace, a gel insert for use in the back brace, an electric stimulator unit, and a pressure relief pillow.

In support of its request for reimbursement, Provider presented Explanations of Benefits (EOBs) reflecting its usual-and-customary charges to other carriers for the same DME items and full reimbursement by those carriers. Provider also elicited testimony from its office manager, Keith Payne, who testified about Provider's cost for each of the items as well as its provision of instructional services to the patient when the equipment is dispensed. Because the EOBs together with Mr. Payne's testimony constituted evidence of fair-and-reasonable value for the equipment, Provider argued, the burden shifted to Carrier to demonstrate how it derived its reimbursement rate and why it was the more reasonable rate. Provider characterized Carrier's reimbursement rate, which was based on the Medicare system's INGENIX numbers, as apparently having been "pulled out of the air." Provider also referred to several prior SOAH decisions in support of its position.[1]

Carrier pointed out that in the absence of a reimbursement methodology, a provider must present documentation and evidence demonstrating that the amount billed was fair and reasonable. Arguing that presenting invoices of what other carriers have paid is insufficient for this purpose, Carrier referred to SOAH Docket No. 453-01-1179.M4, where the ALJ held that "fair and reasonable" is the only standard in Texas actually determinative of what should be paid for medical goods or services. Carrier noted that according to the ALJ in that case, the usual-and-customary and fair-and-reasonable concepts coincide only where the provider demonstrates that the usual-and-customary charges achieve effective cost control, analyzes the equivalent standard of living of another individual provided the same treatment, and allows for consideration regarding an increased security of payment to the Provider. Carrier argued that simply presenting testimony about what a

[1] Provider cited SOAH Docket No. 453-01-1217.M4 for the proposition that the *Durable Medical Equipment Guideline*, at Ground Rule 4, require that durable medical equipment be billed at the provider's usual-and-customary rate and reimbursed either at a pre-negotiated rate or, if there is such rate, at the fair-and-reasonable rate. Because there was no pre-negotiated rate, the ALJ determined the rate charged to and reimbursed by other carriers to be reasonable.

Provider also cited Docket No. 453-01-1001.M5, where the ALJ determined that the Medicare guidelines were not to be used in deriving a fair-and-reasonable rate.

provider has paid its suppliers for durable medical equipment and demonstrating what other carriers have paid in reimbursement does not meet the requirements for proving the amount billed was fair-and-reasonable.

**B. Analysis and Conclusion**

Having challenged the MRD's decision, Provider recognized its burden to present evidence demonstrating that its billings for the durable medical equipment were fair-and-reasonable. Upon doing so, the burden would shift to Carrier to prove its reimbursement rates were fair and reasonable. The initial determination for the ALJ, then, is whether Provider met its burden. It did. Obviously, the production of invoices reflecting the exact amount paid for the equipment would have conclusively established Provider's exact costs and aided in the ultimate determination of whether they were reasonable. Nonetheless, the testimony of Provider's office manager sufficiently accomplished the task of producing *prima facie* evidence of such costs and their reasonableness.

The ALJ was not persuaded by Provider's argument, however, that the payment of Provider's usual-and-customary rates by other carriers established the rates as fair and reasonable. While Section IV. of the *Durable Medical Equipment Ground Rules* states that DME items should be billed at the Provider's usual-and-customary rate, it requires reimbursement at a fair-and-reasonable rate when there is no specific Maximum Allowable Reimbursement (MAR) and the parties have not pre-negotiated such services.

Section 413.011 of the Act, cited by Carrier in support of its argument, addresses standards by which the Commission shall determine appropriate fees in its reimbursement and treatment guidelines. This provision, which establishes the Commission's responsibilities in creating reimbursement and treatment guidelines, does not directly apply to rates of reimbursement that shall apply when there are no guidelines and the parties have not pre-negotiated a rate. Nevertheless, it clearly expresses the Legislature's intent that medical fees not only be fair-and-reasonable but also be designed to ensure quality medical care and achieve effective medical cost control.

Notwithstanding Provider's failed argument equating usual-and-customary with the fair-and-reasonable standard, it did show that its charges were consistent with the § 413.011 standards and the *Durable Medical Equipment Ground Rules*. In response, Carrier failed to counter Provider's evidence by showing either that the billings were not consistent with the Labor Code or Commission standards or that its own reimbursement rate was more reasonable in light of those standards. Consequently, Provider is entitled to full reimbursement at the billed amount of $865.00.

## IV. Findings of Fact

1. On November 7, 2001, OxyMed, Inc. (Provider) filled a prescription for items of Durable Medical Equipment (DME) and billed Camden Fire Insurance Association (Carrier) $865.00 for the equipment.

2. The DME items consisted of a back brace, which cost Provider $150.00 and was billed at $215.00; a gel insert for the brace, which cost Provider $15.00 and was billed at $50.00; an electric stimulation unit, which cost $350.00 and was billed at $475.00; and a pressure relief pillow, which cost $80.00 and was billed at $125.00.

3. In conjunction with its sale of the gel insert, Provider spends at least 30 minutes with the patient providing instruction on using the insert, including how to insert it, how to warm and cool it, and how to wear it.

4. In conjunction with its sale of the electric stimulation unit, Provider instructs the patient on how to use it.

5. Provider bills other carriers the same for the four DME items.

6. Carrier reimbursed Provider $481.50 for the four DME items.

7. After the Medical Review Division of the Texas Workers' Compensation Commission issued its Medical Dispute Resolution Findings and Decision, Provider timely requested a hearing before the State Office of Administrative Hearings.

8. Notice of the hearing was sent July 30, 2002.

9. The notice contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted.

## V. Conclusions of Law

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented pursuant to the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. §413.031 (Vernon Supp. 2002).

2. SOAH 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. CODE ANN. ch. 2003 (Vernon 2002).

3. The hearing was conducted pursuant to the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001 (Vernon 2002) and 28 TEX. ADMIN. CODE (TAC) §§133.305.

4. Provider has the burden of proof in this matter. 28 TAC §148.21(h).

5. Provider proved that, consistent with TEX. LABOR CODE ANN. § 413.011 and Section IV. of the Commission's *Durable Medical Equipment Ground Rules,* the amount billed for the dispensed items of DME was fair and reasonable.

6. Provider should be reimbursed at the billed amount of $865.00.

## ORDER

**IT IS ORDERED** that Carrier, Camden Fire Insurance Company, shall reimburse Provider, OxyMed, Inc., the sum of $383.50, which constitutes the difference between the amount billed by OxyMed and the amount reimbursed by Camden for items of durable medical equipment dispensed by OxyMed on November 7, 2001.

**Signed this 13th day of December, 2002.**

**GARY W. ELKINS**
**ADMINISTRATIVE LAW JUDGE**
**STATE OFFICE OF ADMINISTRATIVE HEARINGS**