SOAH DOCKET NO. 453-02-3846.M4
[MDR TRACKING NO. M4-02-2393-01]

OXYMED, INC.,	§	**BEFORE THE STATE OFFICE**
Petitioner	§	
	§	
VS.	§	
	§	**OF**
TEXAS WORKERS' COMPENSATION	§	
COMMISSION and FREEMONT	§	
INDUSTRIAL INDEMNITY COMPANY,	§	**ADMINISTRATIVE HEARINGS**
Respondents.	§	

DECISION AND ORDER

Oxymed, Inc., (Provider) appealed the decision of the Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD) denying additional reimbursement for durable medical equipment (DME) it provided to Claimant,____. At issue is the fair and reasonable reimbursement amount for the DME.

As set out below, the Administrative Law Judge (ALJ) concludes the fair and reasonable reimbursement amount for the DME in question is $5,000, and Provider is entitled additional reimbursement of $750.

I.
JURISDICTION, NOTICE AND PROCEDURAL HISTORY

There were no contested issues of jurisdiction or notice. Therefore, those matters will be addressed in the findings of facts and conclusions of law without further discussion here.

Provider appealed MRD docket number M4-02-2329-01 issued on June 28, 2002. The decision found Provider was not entitled additional reimbursement for the DME it provided to Claimant. Carrier was billed $5,000 for the DME and reimbursed Provider $4,250. Provider appealed the MRD decision to the State Office of Administrative Hearings (SOAH) and sought additional reimbursement of $750.[1]

A hearing convened on February 10, 2003, with Steven M. Rivas, Administrative Law Judge (ALJ) presiding. Provider appeared and was represented by Peter Rogers, attorney. Carrier appeared and was represented by Steve Tipton, attorney. The hearing adjourned and the record closed the same day.

[1] Other matters were addressed by the MRD, but the parties agreed the only matter before SOAH was the fair and reasonable reimbursement rate for the DME in question.

II.
DISCUSSION

1. Background Facts.

Claimant sustained a compensable back injury on_____. As part of Claimant's ongoing treatment, Claimant was prescribed a pulse electromagnetic frequency (PEMF) device by his treating doctor, Robert J. Henderson.[2] Provider billed Carrier $5,000 for the device and Carrier reimbursed Provider $4,250. The parties agreed the PEMF device is considered durable medical equipment (DME).

2. Fair and Reasonable Rate.

1. DME Ground Rules.

Reimbursement rates for DME are governed by the 1996 Medical Fee Guideline. DME Ground Rules IV and IX provide as follows:

IV. Non listed Items and Documentation of Procedure

> The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. . . .

IX Billing

> C. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be in an amount pre-negotiated between the provider and the carrier or if there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guideline.

There was no pre-negotiated amount for the DME, and there is no corresponding "D" code in the 1991 Medical Fee Guideline. Consequently, the ALJ must determine if $5,000 was Provider's usual and customary rate and whether that amount is fair and reasonable.

2. Provider's position.

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[2] Dr. Henderson prescribed a pulse electromagnetic frequency (PEMF) device on April 23, 2001, per page 19 of the Certified Record. According to documents attached to Provider's response to Carrier's request for production PEMF is also known as an osteogenesis stimulator or bone growth stimulator.

Provider submitted invoices that showed other carriers in the past had reimbursed Provider $5,000 for the same DME. The ALJ identified four separate instances where Provider billed this amount and was paid in full.[3] Provider submitted additional DME invoices that were paid in full but did not contain the DME in question.[4] Provider representative Keith Payne testified that Provider usually purchases the DME in question in bulk for approximately $2,800 each. He explained the markup from $2,800 to $5,000 not only reflects a profit but also covers incidental costs like storage and delivery. Mr. Payne also testified the amount billed to Carrier is the actual retail price of the DME if a customer were to purchase the DME from a retail outlet. Finally, Mr. Payne testified Provider bills the same amount of $5,000 to every carrier for this DME.

3. Carrier's position and the Labor Code.

Carrier conceded Provider customarily bills $5,000 for the DME in question. However, Carrier argued the amount Provider bills for the DME is not fair and reasonable under the provisions of the Labor Code. Specifically, Carrier points out Tex. Lab. Code Ann. § 413.011, which provides:

> (b) Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

Carrier argued this statute defines the phrase "fair and reasonable" and asserted it should be considered when reviewing Provider's evidence. Carrier argued Provider's "handpicked" invoices and payment receipts do not prove $5,000 is a fair and reasonable reimbursement rate because the invoices alone do not establish the Provider met the provisions of the Labor Code.

Carrier asserted a "fair and reasonable" fee, based on this statute, is one that ensures "the quality of medical care" and achieves "effective medical cost control." Therefore, Carrier argued, in order for Provider to be fully reimbursed, it must show the $5,0000 charged to Carrier achieved or displayed "effective medical cost control." Carrier argued since Provider's invoices do not establish "effective cost control," they cannot be considered "fair and reasonable," and should not be paid as billed.

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[3] Pages 25 through 28 of the Certified Record reflect Provider billed $5,000 for this device and was paid in full.

[4] Provider argued it generally receives full reimbursement for its DME invoices.

Next, Carrier contended a "fair and reasonable" fee, based on this statute, is one that does not exceed an amount "charged for similar treatment of an injured individual of an equivalent standard of living." Therefore, Carrier argued, in order for Provider to be fully reimbursed, it must show the $5,000 charged to Carrier did not exceed an amount "an injured individual of an equivalent standard of living" would pay for the DME. Carrier asserted that since the invoices failed to establish that $5,000 did not exceed the fee that would be charged to an injured individual of an "equivalent standard of living," they cannot be considered "fair and reasonable," and should not be paid as billed.

4. Analysis and Conclusion.

The Labor Code statute sheds light on what is "fair and reasonable" but does not specifically direct providers to determine "fair and reasonable" amounts to charge for DME. The statute is instead directed toward the Commission to use as a criteria in establishing medical fee guidelines. Therefore, Carrier's arguments are not compelling.

The DME Ground Rules govern this dispute in absence of a specific fee guideline, and those Ground Rules indicate a carrier shall reimburse the DME provider the fair and reasonable rate for the item in absence of a pre-negotiated amount. Based on the evidence that other carriers paid $5,000 for the DME in question, the ALJ is persuaded $5,000 is a fair and reasonable fee.

This ALJ is also persuaded by other SOAH decisions where the issue was the fair and reasonable amount a provider should be reimbursed for DME. In two cases, the ALJ found in favor of the provider that showed other carriers had paid the usual and customary fee charged by the provider in the past.[5]

III.
FINDINGS OF FACT

1. Claimant____, sustained a compensable back injury on_____.

2. On April 23, 2001, Claimant was prescribed a PEMF (pulse electromagnetic frequency) device by his treating doctor, Robert J. Henderson, M.D.

3. The PEMF device is durable medical equipment (DME).

4. Oxymed, Inc. (Provider), furnished the DME to Claimant and billed Freemont Industrial

[5] SOAH docket 453-01-1001.M4, ALJ Newchurch, April 23, 2001. The provider presented evidence that showed in the past carriers paid the billed amount for the DME in question. The ALJ held the usual and customary rate was also a fair and reasonable rate for the DME. See also SOAH docket 453-01-1217.M4, ALJ Casarez, October 30, 2001. The ALJ held the usual and customary charge for the DME in question was also a fair and reasonable amount where the provider had charged other carriers the same amount $179 for the DME and the other carriers reimbursed the provider.

Indemnity Company (Carrier) $5,000.

5. Carrier reimbursed Provider $4,250 and Provider sought additional reimbursement from the Texas Workers' Compensation Commission (the Commission) Medical Review Division (MRD), which found Provider was not entitled to any additional reimbursement.
6. Provider timely filed a request for hearing before the State Office of Administrative Hearings (SOAH).

7. Notice of the hearing was sent August 8, 2002.

8. 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.

9. The hearing was held February 10, 2003, with Administrative Law Judge (ALJ) Steven M. Rivas presiding and representatives of the Carrier and Provider participating. The hearing was adjourned and the record closed the same day.

10. Provider customarily purchases the DME in question in bulk at $2,800 each. Provider always bills carriers $5,000 for this DME. The markup reflects a profit and covers incidental costs like storage and delivery.

11. Provider has been reimbursed in full in the past by carriers that were billed $5,000 for this DME.

12. A fair and reasonable reimbursement for this DME is $5,000.

13. Provider is entitled to additional reimbursement of $750.

IV.
CONCLUSIONS OF LAW

1. The Commission has jurisdiction over this matter pursuant to Section 413.031 of the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. ch. 401 *et seq*.

2. SOAH has jurisdiction over this proceeding, including the authority to issue a decision and order, pursuant to TEX. LAB. CODE ANN. § 413.031(d) and TEX. GOV'T CODE ANN. ch. 2003.

3. Provider timely filed its request for hearing as specified by 28 TEX. ADMIN. CODE § 148.3.

4. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052, and 28 TEX. ADMIN. CODE § 148.4.

5. The Provider, as Petitioner, has the burden of proof in this matter under 28 TEX. ADMIN. CODE § 148.21(h).

6. The Durable Medical Equipment (DME) Ground Rules found in the Commission's Medical Fee Guideline, adopted by reference at 28 TEX. ADMIN. CODE § 134.201, directly apply in this case.

7. Durable Medical Equipment Ground Rule IX. C provides that DME should be billed at the provider's usual and customary rate, and that reimbursement shall be in an amount pre-negotiated between the provider and the carrier, or, if no amount has been pre-negotiated, at a fair and reasonable rate.

8. Provider billed Carrier its usual and customary charge for the DME it supplied the Claimant.

9. Because there was no pre-negotiated price between the Petitioner and the Carrier, nor was a fee set out in Code D of the Commission's 1991 Medical Fee Guideline for the DME, the Provider's usual and customary charge was a fair and reasonable charge.

10. Based on the above Findings of Fact and Conclusions of Law, Carrier should reimburse Provider an additional $750 for the DME that it provided to Claimant.

ORDER

IT IS, THEREFORE, ORDERED that the Carrier, Freemont Industrial Indemnity Company, shall reimburse Provider, Oxymed Inc., an additional $750 for the DME it provided to Claimant ____.

Signed this 8th day of April, 2003.

STATE OFFICE OF ADMINISTRATIVE HEARINGS

STEVEN M. RIVAS
ADMINISTRATIVE LAW JUDGE