MDR Tracking Number: M4-05-0950-01 **(Previously M4-04-B179-01)**

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 Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 7/26/04.

This AMENDED FINDINGS AND DECISION supersedes M4-04-B179-01 rendered in this Medical Payment Dispute involving the above requestor and respondent.

The Medical Review Division's Decision of 9-21-04 was appealed and subsequently withdrawn by the Medical Review Division applicable to a Notice of Withdrawal of 10-7-04. The Respondent appealed the Decision to an Administrative Hearing on 9-27-04. The Decision was withdrawn because it did not address issue of "A-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600."

I. DISPUTE

Whether there should be additional reimbursement for dates of service 7/30/03 through 8/29/03 and 8/30/03 through 9/29/03 for HCPCS code E1399 RR.

II. RATIONALE

The services in dispute were denied as, "A-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600." Reconsideration EOBs denied additional reimbursement as, "F-The Charge for this procedure exceeds the Fee Schedule or usual and customary values as established by Ingenix."

The Requestor's position statement received 8/4/04 states, "…Rental of RS4I Sequential Stimulator…a combination 4 channel muscle stimulator/interferential electrotherapy device. Payment has been made based on old fee guidelines for E0745; which had a D code in the pre 1996 fee schedule, which is not a comparable device as it provides only muscle stimulation. The Commission has not established a maximum allowable for the RS4I Sequential Stimulator. The RS4I provides 2 modalities…4 channel muscle stimulation plus interferential electrotherapy, providing equivalent therapy of 2 devices, therefore a higher fee allowance is reasonable and warranted. The RS4I provides pain relief and promotes muscle recovery to the injured worker. There are no fee guidelines for devices billed under E1399. Fee guidelines call for reimbursement at fair and reasonable rates. RS Medical has billed for this product at our published list price. Therefore, reimbursement for this unit under the fee schedule for E0745, which is a muscle stimulator only, is neither fair nor reasonable. We have provided product information and pricing along with the prescription from the patient's doctor of record. We are also including copies of EOBs from carriers who are paying at our list price."

The Carrier's submitted response received 8/16/04 states in part, "…We base our payments on the Texas Fee Guidelines and the Texas Workers' Compensation Commission Acts and Rules. The charges in dispute are for rental of a muscle stimulator for 07/30/03 through 08/30/03. The provider has billed $250.00 for each month. Reimbursement has been made at the rate of $150 per month as

stipulated by the 1991 fee schedule. The Medical Fee Guidelines state that fair and reasonable will be the value assigned in the 1991 fee schedule. This is the amount routinely reimbursed by Liberty Mutual for neuromuscular stimulator rental. There is no clinical proof that the equipment supplied by RS Medical has any greater advantage than another stimulator. Enclosed please find a copy of a letter from TWCC regarding DME code E1399, which states payment for this code is listed as 'carrier discretion'. This means the carrier will determine the amount to be reimbursed based on rule 134.202 (C) (6)."

There is no Maximum Allowable Reimbursement for HCPCS Code E1399. Per Commission Rule 133.307 (j)(1)(F), states in part, "…if the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 403.011…"

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

"A-Pre-authorization was required, but not requested for this service per TWCC Rule 134.600." Rule 134.600(h)(11), states that preauthorization is required for, "all durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all tranecutaneous electrical nerve stimulation (TENS) unit." The requestor billed $250.00 per month for rental of RS4I Four Channel Muscle/Interferential Stimulator Unit. The two months in dispute equals $250.00 X 2 = $500.00 cumulative rental. $500.00 does not exceed the threshold of excess of $500.00; therefore preauthorization was not required.

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MFG MAR	Maximum Allowable Reimbursement (MAR) x Conversion Factor of 125%	REFERENCE	RATIONALE:
7/30/03 thru 8/29/03	E1399 RR	$250.00	$150.00	A, F	No MAR	Not applicable for dates of service prior to 8-1-03. For dates of service after 8-1-03 –No MAR	Medical Fee Guideline; Rule 133.307 (j)(1) (F); Rule 133.307 (g)(3)(D); and DME Ground Rule (IX)(C) Rule 134.201 Rule 134.202 Section 413.011	Rationale for dates of service 7-30-03 and 7-31-03: "D" codes in '91 Medical Fee Guideline do not contain a similar description of the same RS4I Four Channel Muscle/Interferential Stimulator Unit in dispute, therefore, there is no established MAR. On this basis, this item is subject to fair and reasonable reimbursement per 413.011. Requestor has submitted redacted documentation to support their position that their monthly rental rate is fair and reasonable and that the Carrier's rate of reimbursement is not fair and reasonable. Rationale for DOS after

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MFG MAR	Maximum Allowable Reimbursement (MAR) x Conversion Factor of 125%	REFERENCE	RATIONALE:
								8-1-03: Since there is no established MAR, this item is subject to fair and reasonable reimbursement per 413.011. Reimbursement is recommended in the amount of $100.00.
8/30/03 thru 9/29/03	E1399 RR	$250.00	$150.00	A, F	No MAR	No MAR	Medical Fee Guideline effective 8/1/03; Rule 133.307 (j) (F); Rule 133.307 (g)(3)(D); and	DMEPOS or the DME Medical Fee Guideline does not contain a similar description of the same RS4I Four Channel Muscle/Interferential Stimulator Unit in dispute therefore, there is no established MAR. On this basis, this item is subject to fair and reasonable. Requestor has submitted redacted documentation to support their position that their monthly rental rate is fair and reasonable and that the Carrier's rate of reimbursement is not fair and reasonable. Reimbursement is recommended in the amount of $100.00.
Total								Total reimbursement recommended is $200.00.

III. AMENDED DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement of in the amount of $200.00. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $200.00 plus all accrued interest due at the time of payment to the Requestor within 20-days receipt of this Order.

The above Amended Decision and Order are hereby issued this 27th day of October 2004.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division