Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: RS Medical P.O. Box 872650 Vancouver, WA 98687-2650	MDR Tracking No.: M4-05-2863-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Guardian Industries Corp. Rep Box #15	Date of Injury: Employer's Name: Guardian Industries Corporation Insurance Carrier's No.: 21881355811531

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor states: "There is no established fee schedule for this device. Fair & Reasonable not established by documentation".

Principle Documentation: 1. DWC-60
2. CMS-1500
3. EOB

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent states they paid in accordance to the recommendation by the billing company.

Principle Documentation: 1. DWC-60 Response

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	Denial Code	CPT Code(s) or Description	Part V Reference	Additional Amount Due (if any)
12/30/04	M/D	E1399-RR	1	$00.00
TOTAL DUE				$00.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Section 413.011(a-d) titled (Guidelines and Medical Policies), and Commission Rule 134.202 titled (Medical Fee Guideline) effective August 1, 2003, set out reimbursement guidelines.

The CPT Code in dispute E1399-RR was denied as "M" Reduced to fair and reasonable.

1. The HCPCS Level II Code E1399, Durable Medical Equipment, miscellaneous, is used to bill for DME items when a more specific code is not available. These items vary greatly in reimbursement. This code does not have an established value set by CMS nor the Division.

Division Rule 134.202(c) (6), states that for products for which CMS or the Division does not set an amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work or resource commitment. Although RS Medical has submitted product features and information, the manufacturer has not submitted manufacturing cost information on the product. RS Medical states that due to the unique features of the product, higher reimbursement from other muscle stimulators is warranted. RS Medical also provides EOB's from other carriers who have reimbursed the full amount bill at $250.00 for rental. The EOB provided by RS Medical only illustrate the highest amount paid by carriers and do not show the full range of payments made by carriers.

MDR does not believe that reimbursement of 100% of the charges is fair and reasonable. Reimbursement of 100% of charges. gives the manufacturer sole control over the amount billed and reimbursed, this is not effective medical cost control for the workers' compensation system. The manufacturer has not provided convincing evidence to justify increased reimbursement. Unless the manufacturer provides

convincing evidence to provide for reimbursement otherwise the Division refers to the other values previously discussed. While the RS4i is not exactly the same as a TENS unit, the RS4i is similar to a TENS unit. Therefore, the Division will use the assigned relative value for a similar type product, E0745, Neuromuscular Stimulator, at a midpoint between the CMS national average payment ($82.80) multiplied by 1.25 and the national average commercial reimbursement (180.01) for the E0745. The commercial reimbursement is used to recognize the unique features of the RS4i that makes the RS4i different from the E0745, Neuromuscular Stimulator.

For date of service in calendar year 2004 the Division reimbursement for the RS4i is calculated as follows:
$82.80 x 1.25 = $103.50 +$180.01 =$283.51 ÷ 2 = $141.76.

According to the Requestors Table Of Disputed Services they received payment in the amount of $150.00 from the Carrier. Therefore no additional reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.202

PART VII: DIVISION DECISION AND ORDER

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 not** entitled to reimbursement.

Ordered by:

Authorized Signature	Typed Name	06/09/06 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.