



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.: M4-05-4358-01 |
| | Claim No.: |
| | Injured Employee's Name: |
| Respondent's Name and Address: City Of San Antonio REP BOX: 42 | Date of Injury: |
| | Employer's Name: City Of San Antonio |
| | Insurance Carrier's No.: 0027902819 |

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "...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 RS41 Sequential Stimulator. The RS41 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..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOBs

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "...The requestor bears the burden of proof to demonstrate the fairness of its charges. The requestor must show that the amount requested is fair and reasonable, not usual or customary or what fees they charge. The requestor has failed to meet its burden. The requestor's additional information does not contain proper justification for billed costs. Essentially, the provider maintains it has billed a fair and reasonable amount, yet fails to provide any information which might justify its bill. Instead, it merely supplies EOBS from selected carriers which ostensibly demonstrate higher rates of reimbursement for items similar to those made the basis of this dispute..."

Principle Documentation: 1. Position Summary
2. EOBs

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) |
|--------------------|-------------|----------------------------|------------------|--------------------------------|
| 02/16/04-03/15/04 | M/O | E-1399-RR | 1 | \$0.00 |
| TOTAL DUE | | | | \$0.00 |

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 Respondent used payment exception code "M – Payment is reduced from the billed amount for treatment/services for which TWCC has not set a maximum allowable reimbursement." Reconsideration exception code "O - Previously recommended amount has not been changed."

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 EOBs from other carriers who have reimbursed the full amount bill at \$250.00 for rental. The EOBs 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 make 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 \times 125\% = \$103.50 + \$180.01 \div 2 = \141.76 . The Respondent made a total payment in the amount of \$150.00. 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 additional reimbursement.

Decision by:

Gloria Covarrubias

06/13/06

Authorized Signature

Typed Name

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.