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- 05-4697-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Home Assurance Co. C/O Flahive, Ogden and Latson Rep Box: 19	Date of Injury: Employer's Name: CitiGroup Inc. Insurance Carrier's No.: 234CBAKZ0808

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 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."

Principle Documentation:

1. DWC-60/Table of Disputed Service
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Principle Documentation:

1. Position Summary

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)
03/05/04	G/O	A4556	A1-2	$ 60.72
03/05/04	G/O	A4557	A 3-4	$ 26.38
TOTAL DUE				$ 87.10

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

A. The disputed issue: Whether payment is due the Requestor for DME supplies known as A4556, A4557.

1. The Requestor billed $80.00 for 8 units for (electrodes) under HCPC code A4556**.** The insurance carrier denied payment based upon global fee concept. Per 2004 DMEPOS, the monthly rental of RS4i does not include additional replacement supplies, including electrodes, conductive paste/gel, tape/other adhesive and adhesive remover, skin preparation materials, and batteries; therefore, the insurance carrier incorrectly denied reimbursement based upon "G."

2. Per 2004 DMEPOS the MAR for HCPC code A4556 is $15.18/ pr. The Respondent made a total payment in the amount of $ 00.00. Based upon the previously paid amount the Division finds that additional reimbursement is due for HCPC Code A4556, in the amount of $ 60.72

3. The Requestor billed $40.00 for 1 unit for (Cableset Combo) under HCPC code A4557. The insurance carrier denied payment based upon global fee concept. Per 2004 DMEPOS, the monthly rental of RS4i does not include additional replacement supplies, including electrodes, conductive paste/gel, tape/other adhesive and adhesive remover, skin preparation materials, and batteries; therefore, the insurance carrier incorrectly denied reimbursement based upon "G."

4. Per 2004 DMEPOS the MAR for HCPC code A4557 is $26.38. The Respondent made a total payment in the amount of $ 00.00. Based upon the previously paid amount the Division finds that additional reimbursement is due for HCPC Code A4557, in the amount of $ 26.38

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1
28 Texas Administrative Code Sec. §134.202 (b) & (c)(6)

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 entitled to additional reimbursement in the amount of $87.10 plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

	David B. Brown	7/31/06
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.