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.: M4-05-5049-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: American Manufacturers Mutual Insurance Rep Box # 42	Date of Injury: Employer's Name: Labor Ready Inc. Insurance Carrier's No.: 8609290175042X

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary states that there is no established HCPC for this device.

Principle Documentation:

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

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Respondent's Position Summary states that the provider is not entitled to any further reimbursement.

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)
03/15/04	F	E-1399-RR	1	$29.87
TOTAL DUE				$29.87

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.

According to the EOB provided by the Requestor the Respondent has denied payment for HCPCS Code E-1399 as "145 – Please resubmit with appropriate Fee Schedule code" and "F – Fee Guideline MAR Reduction."

1. For date of service on or after August 1, 2003, Division Rule 134.202(b), 2002 Medical Fee Guideline, requires health care providers to apply the Medicare program coding, billing and reporting payment policies. The Centers for Medicare and Medicaid Services, partners with the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) to provide guidance to manufacturers and suppliers on the proper use of the Healthcare Common Procedure Coding System (HCPCS), the means by which durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) services are identified for Medicare billing. Manufacturers and suppliers are instructed by CMS and through the DMERC supplier manual and advisories to contact the SADMERC HCPCS Unit to obtain proper billing codes for DMEPOS items.

SADMERC representatives have determined that the RS4i is properly coded to E1399. According to SADMERC, none of the other more specific HCPCS billing codes accurately describe this piece of equipment. With this decision, SADMERC has established that the RS4i is not the same as a TENS unit. While the RS4i is not exactly the same as a TENS unit, the RS4i is similar to a TENS unit. The manufacturer of the RS4i has not resubmitted further reconsideration and analysis on their product since the initial SADMERC decision to place in a miscellaneous HCPCS billing code.

The coding by the provider of the RS4i was correct.

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. By not paying any amount, the carrier failed to comply with this rule. For date of service in calendar year 2004 the Division reimbursement for the RS4i is calculated as follows $82.80 x 125% = $103.50 + $180.01 ÷ 2 = $141.76. The Respondent made a reimbursement in the amount of $111.89. Therefore, reimbursement in the amount of $29.87 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 entitled to additional reimbursement in the amount of $29.87 plus all accrued interest due at the time of payment to the Requestor within 30 days receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
		06/09/06

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.