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: TGZ Acquisition Co., dba JACE Systems 2 Pin Oak Lane, Suite 200 Cherry Hill, New Jersey 08003-1020	MDR Tracking No.: M4-05-5443-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: Alief Independent School District C/o Harris & Harris Rep Box # 42	Date of Injury: Employer's Name: Alief Independent School District Insurance Carrier's No.: ALF05803

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"…Per Dr. Gerard Gabel, we supplied Ms. ___ with a Dynamic Tension Splint for Ganglion of her left wrist. We billed with HCPCS level II code E1805NU and billed our UCR of $1595.00. Medicare lists this code as rental reimbursable @ $107.39 per month…This Dynamic Tension Splint was manufactured as a single patient sale item. Per the carrier's request we submitted our purchase invoice, which shows a discounted price and doesn't factor in the other costs of providing service to this injured worker. The carrier paid $246.68 for the purchase of this unit and processed it as a RR (rental). The carrier's methodology appears to be 10% above our cost. The reimbursement we received does not cover the cost of doing business…I am requesting this invoice to be reprocessed at a fair & reasonable rate. Per rule §134.202 section 6, D: for services that do not have an established value the lesser of the following shall apply. 1. MAR amount A. No MAR established for HCPCS level II code E1805 NU (sale). Medicare lists this item as a rental only. Medicare required item to rent for 13 months before purchasing. Medicare's monthly reimbursement is $107.39. ($107.39 x 13 months = $1396.07) 2. The provider's UCR charge A. Our UCR $1595.00 3. Negotiated or contracted amount A. I have attached a fax that was sent to the carrier for the purpose of obtaining authorization. This document shows our UCR and states sale item. The carrier didn't dispute or negotiate at that time; the charge appeared to be acceptable… "

Principle Documentation:
1. Requestor's position summary
2. DWC 60/Table of Disputed Services
3. CMS 1500
4. Invoice of item purchased
5. Service Agreement of item purchased

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

"No MAR reimbursed. CMS/TWCC has not established a relative unit/payment amount. Carrier assigned a payment based on a nationally recognized publication."

Principle Documentation:
1. Respondent's position summary
2. TWCC 60/Table of Disputed Services
3. DMEPOS Fee Schedules
4. Letter of Medical Necessity for item purchased
5. Invoice of item purchased
6. Service Agreement of item purchased

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)
05/21/04	M	E1805 NU (Dynamic Tension Wrist Splint)	1	$1,348.42
TOTAL DUE				$1,348.32

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.

1. HCPCS Code E1805 NU for date of service 05/21/04 was changed by the carrier to HCPCS Code E1805 RR and denied as "M—No maximum allowable reimbursement". There is no Maximum Allowable Reimbursement for HCPCS Code E1805. Per Commission Rule 133.307(j)(F), "…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 Requestor's submitted documentation substantiates their position that their billed amount is fair and reasonable and that the Carrier's reimbursement is not fair and reasonable. The request for preauthorization submitted by the health care provider included the cost of the DME item. The respondent's preauthorization nurse approved the request without disputing the cost. The carrier reimbursed the Requestor $$246.68. Therefore, additional reimbursement in the amount of $1,348.32 ($1,595.00 - $246.68 = $1,348.32) 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
28 Texas Administrative Code Sec. §133.307(j)(F)

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 **$1,348.32**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 30-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	06/02/06 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.