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.: M4-05-9328-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: St. Paul Fire & Marine Insurance Rep Box#05	Date of Injury: Employer's Name: ACE Hardware Corp Insurance Carrier's No.: 3976135629078X

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Requestor's Position Summary: "Insurance changed the billed code from E1399 to E0745. This code does not accurately describe our device. There is no established fee schedule 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: "Paid at fair & reasonable- the code does accurately reflect the device- either way 111.89 is fair & reasonable reimbursement…"

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)
06/12/04-07/11/04	F, D	E1399-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 changed the HCPCS code used by the Requestor and allowed a payment with payment exception code F- "Effective 8-1-03 invalid code used. Code assigned appears to most accurately reflect services rendered" and D- "Disallowed; Provider previously billed visit/service on this date."

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. 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 x 125% = $103.50 + $180.01 ÷ 2 = $141.76. The Respondent made a total payment in the amount of $111.89. Therefore, additional reimbursement in the amount of $29.87 ($141.76 - $111.89) 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 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:

	Benita Diaz	06/09/06
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.