

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 11/18/03.

### **I. DISPUTE**

Whether there should be additional reimbursement for dates of service 1/15/03 and 5/18/03. The Carrier denied reimbursement as “F Z560 – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix. A X170 – Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.”

### **II. FINDINGS**

On 1/05/04, the Requestor submitted a withdrawal letter for the services denied as unnecessary medical. On 1/08/04, a Notice was faxed to the Requestor to submit additional documentation necessary to support the fee charges and to challenge the reasons the Respondent had denied reimbursement within 14 days of the requestor’s receipt of this Notice.

### **III. RATIONALE**

#### **Date of Service 1/15/03; HCPCS Code L0430**

The Requestor billed \$1,800.00 for a TLSO, anterior-posterior-lateral control, with interface material custom fitted. The Carrier reimbursed \$1,642.76. The Carrier denied additional reimbursement as “F – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.” There is no MAR for this durable medical equipment. Pursuant to Rule 133.304 (c) “...The explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions....” Therefore, this date of service will be reviewed using the 1996 MFG.

The Requestor is required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement per Rule 133.307(g)(3)(D). The Requestor has submitted as their additional documentation, a letter describing the “Custom Molded TLSO Body Jacket”, a prescription for the TLSO, medical office notes and a letter of medical necessity from the Provider.

The Respondent in this case has provided a methodology as required by the rule while the Requestor’s documentation does not sufficiently justify that the Respondent’s reimbursement was not fair and reasonable. The Respondent reimbursed the Requestor \$1,642.76 per their usual and customary reimbursement per geographical area. No additional reimbursement is recommended for HCPCS Code L0430.

**Date of Service 5/18/03; HCPCS Code E0745**

The Requestor billed \$375.00 for the rental of a Neuromuscular Stimulator. The Carrier denied reimbursement as “A x170 – Pre-authorization was required, but not requested for this service per TWCC Rule 134.600.” According to TWCC Rule 134.600(11) pre-authorization is not required for a Neuromuscular Stimulator. Only Transcutaneous Electrical Nerve Stimulators require pre-authorization. According to the 1996 MFG DME GR, (IX)(C), “...A fair and reasonable reimbursement shall be the same as the fees set for the “D” codes in the 1991 Medical Fee Guideline. HCPCS code E0745, a Neuromuscular Stimulator has a “D” code and the monthly rental is \$150.00. On this basis, reimbursement is recommended in the amount of \$150.00.

**IV. DECISION & ORDER**

Based upon the review of the disputed healthcare services within this request, the Division has determined that the Requestor **is** entitled to reimbursement for HCPCS code E0745 in the amount of **\$150.00**. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby **ORDERS** the Respondent to remit **\$150.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Decision and Order is hereby issued this 04th day of May 2004.

Pat DeVries  
Medical Dispute Resolution Officer  
Medical Review Division

PD/pd