MDR Tracking Number: M5-04-4055-01

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 7-26-04.

I. DISPUTE

Whether there should be additional reimbursement for E1399-NU for date of service 08-01-03 denied by the carrier as "M – No MAR" and "C – Negotiated Contract Price" and reimbursement for A4556 for date of service 9-22-03. The EOB for date of service 9-22-03 does not have a payment exception code or reason for denial.

II. RATIONALE

On 9-14-04, the Division submitted a Notice to the Requestor notifying them they failed to make payment of the IRO fee as required by Commission Rule 133.308(r)(1)(B). The Requestor had submitted a withdrawal of the medical necessity portion of this dispute on 8-26-04. Per Rule 133.307(g)(3), the Notice also requested 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 the Notice.

Date of Service 8-01-03; E1399-NU (RS4i Four Channel Muscle/Interferential Stimulator

DMEPOS or the Texas Medicaid Fee Schedule DME/Medical Report J for HCPCS does not contain a similar description of the same RS4i Four Channel Muscle/Interferential Stimulator Unit in dispute, therefore, there is no established MAR. On this basis, this item is subject to fair and reasonable. Requestor has submitted redacted documentation to support their position that their purchase rate is fair and reasonable and that the Carrier's rate of reimbursement is not fair and reasonable. However, the Carrier has also denied reimbursement as "C - Negotiated Contract Price ". The Requestor failed to present pertinent information to dispute or challenge the Carrier's position regarding a contract. On this basis, additional reimbursement is not recommended.

Date of Service 9-22-03; A4556 (Electrodes 4 pair)

Per TWCC Rule 133.304 (c), "…the explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s)…" The Carrier failed to submit sufficient EOBs which included a valid denial. This service will be reviewed utilizing the Medical Fee Guideline effective 8/01/03. Per Rule 134.202(c)(2)(A), reimbursement according to DMEPOS multiplied by 125% is $60.72 ($15.18 x 4 pair). Therefore, reimbursement in the amount of $60.72 is recommended.

III. DECISION

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to date of service 9-22-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2).

This Order is hereby issued this 22nd day of October 2004.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division