

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 8/09/04.

I. DISPUTE

Whether there should be additional reimbursement for date of service 5/05/04. The Carrier denied reimbursement as “U – Unnecessary medical treatment and or services. M – Reduced to fair and reasonable. F – Reduced to the Medical Fee Guideline.”

II. FINDINGS

On 9/03/04, a Notice was sent 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. On 9/20/04, the medical necessity portion of the dispute was withdrawn. The Requestor submitted an updated Table of Disputed Services showing additional reimbursement from the Carrier.

III. RATIONALE

HCPCS Code E0218-RR; Water Circulating Cold Pad with Pump (\$770.00)

The Carrier made reimbursement in the amount of \$654.50. They denied additional reimbursement as “M – Reduced to fair and reasonable; allowance represents 85% of the provider’s charge.” There is no MAR for E0218. Rule 134.202 (c)(6) states, “for products and services for which CMS or the commission does not establish a relative value unit and/or a payment 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 and resource commitments.” The Carrier has established a relative value; therefore, no additional reimbursement is recommended.

HCPCS Code E0249-NU; Pad for Water Circulating Unit (\$215.00)

The Carrier made reimbursement in the amount of \$124.50. They denied additional reimbursement as “F – Reduction according to Medical Fee Guideline.” According to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) 2004 Fee Schedule for Texas, the reimbursable amount is \$90.60. The MAR is $\$90.60 \times 125\% = \113.25 . Therefore, no additional reimbursement is recommended.

CPT Code 99002 (\$125.00)

The Carrier denied reimbursement as “F – Reduction according to Medical Fee Guideline. Disallowed: shipping/handling and tax are not reimbursed under Texas Workers’

Compensation.” There is no MAR for this service. The Requestor states on their Table of Disputed Services, “Not shipping/handling fee.” The Requestor did not submit relevant medical documentation in accordance with Rule 133.307(g)(3)(B); therefore, a review cannot be conducted. Reimbursement is not recommended.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the Requestor **is not** entitled to reimbursement.

The above Findings and Decision is hereby issued this 1st day of November 2004.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd