DOCKET NO. 453-02-3802.M4
[MDR TRACKING NO. M4-02-2176-01]

RS MEDICAL, *Petitioner*	§	**BEFORE THE STATE OFFICE**
V.	§	**OF**
TEXAS WORKERS' COMPENSATION COMMISSION and Z.C. INSURANCE COMPANY, *Respondents*	§	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. STATEMENT OF THE CASE

The Petitioner RS Medical provided an RS4i neuromuscular stimulator to a workers' compensation claimant who had suffered a compensable injury. The Petitioner billed $250 for the device for each date of service (August 5, 2001, and October 5, 2001), for a total of $500, and used CPT code E1399 each time. That code is listed under the Texas Workers' Compensation Commission's Durable Medical Equipment (DME) Ground Rules as a miscellaneous code to be used when no other HCPCS code applies to the DME or the supplies provided to the injured worker.

The Respondent Z.C. Insurance Company reimbursed the Petitioner $150 per date of service, or a total of $300, on the grounds that it was paying the bill according to the fee guidelines for such equipment. The Petitioner appealed the Respondent's action to the Texas Workers' Compensation Commission (the Commission), and on June 19, 2002, in Medical Dispute Resolution #M4-02-2176-01, the Commission's Medical Review Division (MRD) found that the Petitioner had not presented a letter of medical necessity as required by Sections IX(A) and (B) of the DME Ground Rules.[1] Therefore, the Petitioner was not entitled to the additional reimbursement it sought, according to the MRD.

The Petitioner appealed the MRD's decision, seeking reimbursement of the additional $200 it claims it should have been reimbursed for the device ($500 billed less $300 reimbursed). A hearing

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[1] The cited portions of the DME Ground Rules, Section IX provide:

A. A statement of medical necessity, along with the order or prescription appropriate for the equipment/supplies shall accompany initial claims for the rental or purchase of DME. Any verbal order give by the doctor to the DME provider shall be followed by a written prescription or order prior to billing for the DME equipment/supplies.

B. This statement shall include the medical necessity and specify the following:

1. claimant's diagnosis;
2. prognosis; and
3. the expected duration the equipment or supplies will be required.

was held on the appeal on November 4, 2002, before an Administrative Law Judge (ALJ) of the State Office of Administrative Hearings. The Petitioner appeared by telephone and was represented by Susan Keesee, its Insurance Relations Manager. The Respondent appeared through its counsel, Steven Tipton. The staff of the Commission had earlier waived appearance and did not appear. The parties did not contest notice or jurisdiction and those matters are set out in the findings of fact and conclusions of law. The record was closed at the conclusion of the hearing that day.

At the hearing, the Petitioner contended that the case was actually a dispute over the rate to be paid, and that the MRD went beyond the scope of the Petitioner's original complaint in finding that medical necessity had not been demonstrated. The Petitioner also claimed that it in fact had provided a statement of medical necessity to the Respondent and to the Commission.

The Respondent contended that the Petitioner did not understand the DME Ground Rules, and that the $150 reimbursement per date of service was appropriate. In the Respondent's view, it was required to reimburse the Petitioner only for what is fair and reasonable, which is not the equivalent of the Petitioner's usual and customary charge for the neuromuscular device.

The ALJ finds that the Petitioner is not entitled to the additional reimbursement of $200 because the fair and reasonable reimbursement for the RS4i device is $150 per date of service and the Respondent reimbursed the Petitioner the correct amount. She does, however, agree with the Petitioner that the MRD denied the claim on a basis that was not raised in the carrier's original denial of reimbursement – that the charge for the device exceeded the fee schedule – and the ALJ has some question whether that ground for denial was properly invoked at the MRD.

Under Section IV of the 1996 DME Ground Rules, DME items

> should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. [Providers are to] [u]se the miscellaneous HCPCS code, E1399, when no other HCPCS code is present for the DME or supplies provider to the injured worker. When using E1399, a description of the unlisted equipment/supply is required.

Later, in Section IX(C) of the DME Ground Rules, providers are advised that a fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guidelines.

In this case, the Respondent determined the device provided by the Petitioner to the claimant not to be a miscellaneous item, but a muscle stimulator under CPT Code D0550. The fair and reasonable reimbursement for the rental of a muscle stimulator is $150. (There was no argument or contention here that the reimbursement rate should be other than for rental of the device.) Hence, it reimbursed the Petitioner at the $150 rate for the RS4i. The Petitioner claimed that the RS4i device was a unique product, different than a muscle stimulator, and thus entitled to be reimbursed at its usual and customary charge of $250 per date of service. However, it failed to introduce any

evidence describing the differences between an RS4i and an ordinary muscle stimulator. The preponderant evidence indicates that it is a muscle stimulator, and the fair and reasonable reimbursement for muscle stimulators is $150 under the "D" codes identified in the 1996 and 1991 DME Ground Rules.

To the extent, if any, that medical necessity was or is an issue in the case, the Petitioner would not prevail. First, the prescription for the RS4i, which contains a statement of medical necessity, lacks credibility. (The ALJ sustained the Respondent's objections to its authenticity, admitting it into the record for the limited purpose of showing that it was sent to the Commission with the other documents in the Petitioner's Exhibit 5.) There is no evidence that the claimant's doctor filled out the prescription, and the Petitioner's witness Pam Borgman, the Petitioner's billing manager, testified she did not know who completed the form. She admitted it could have been the Petitioner's account manager, whose typed name appears at the bottom of the prescription.[2] The statement of medical necessity on the prescription is typed, and seems to be in the same font as that used for the account manager's name. The Petitioner did not call any witnesses to establish who completed the prescription. It may well have been the claimant's doctor, but other evidence indicates it also may well have been the Petitioner's representative.

Second, even if the prescription and the statement of medical necessity had been admitted for all purposes, the statement of medical necessity does not comply with Section IX(B) of the DME Ground Rules. The statement of medical necessity does not contain a prognosis, nor does it give the expected duration the RS4i would be required, as required by that portion of the Ground Rules.

For these reasons, the ALJ finds that the Petitioner failed in its burden of proof, and did not establish it is entitled to the additional $200 reimbursement. The MRD decision should be upheld.

II. FINDINGS OF FACT

1. The Petitioner RS Medical provided an RS4i neuromuscular stimulator to a workers' compensation claimant who had suffered a compensable injury.

2. The Petitioner billed $250 for the device for each date of service (August 5, 2001, and October 5, 2001), for a total of $500, and used CPT code E1399, a miscellaneous code, each time.

3. The Respondent Z.C. Insurance Company reimbursed the Petitioner $150 per date of service, or a total of $300, for the RS4i provided to the claimant.

4. The Petitioner appealed the Respondent's action to the Texas Workers' Compensation Commission (the Commission).

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[2] Exh. 5, p. 10.

5. On June 19, 2002, in Medical Dispute Resolution #M4-02-2176-01, the Commission's Medical Review Division (MRD) found that the Petitioner did not present a letter of medical necessity as required by Sections IX(A) and (B) of the DME Ground Rules, and ruled the Petitioner was not entitled to the additional reimbursement.

6. The Petitioner appealed the MRD's decision, seeking reimbursement of an additional $200 ($500 billed less $300 reimbursed).

7. On August 8, 2002, the staff of the Commission issued a notice of hearing apprising the parties of a hearing on the Petitioner's appeal.

8. A hearing was held on the appeal on November 4, 2002. The Petitioner and the Respondent appeared and participated in the hearing. The staff of the Commission waived appearance and did not appear.

9. There is no evidence the RS4i is anything other than a muscle stimulator.

10. There is no evidence the RS4i is a unique product.

III. CONCLUSIONS OF LAW

11. The Texas Workers' Compensation Commission (the Commission) has jurisdiction over the issue presented pursuant to the Texas Workers' Compensation Act (the Act), TEX. LAB. CODE ANN. §413.031.

12. The State Office of Administrative Hearings has jurisdiction over all matters related to the hearing in this case, including the issuance of this decision and order, pursuant to TEX. GOV'T CODE ANN. ch. 2003 and pursuant to §413.031(k) of the Act.

13. Notice of the hearing was proper and timely, as required by the Administrative Procedure Act, TEX. GOV'T CODE ANN. ch. 2001.

14. The 1996 Durable Medical Equipment (DME) Ground Rules, Section IX(C), direct the use of the "D" codes in the 1991 Medical Fee Guideline for determining what is a fair and reasonable reimbursement for DME.

15. Pursuant to the 1991 DME Ground Rules, muscle stimulators are assigned CPT code D0550.

16. Under the 1991 DME Ground Rules, the fair and reasonable rate of reimbursement for muscle stimulators, CPT code D0550, is $150.

17. The Petitioner is not entitled to additional reimbursement for the RS4i for the dates of

service August 5, 2001, and October 5, 2001.

ORDER

IT IS, THEREFORE, ORDERED that the Petitioner is not entitled to additional reimbursement for the RS4i provided to the claimant on August 5, 2001, and October 5, 2001.

SIGNED January 3, 2003.

CATHLEEN PARSLEY
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS