Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Center for Pain Recovery

Respondent Name
Transcontinental Insurance Co

MFDR Tracking Number
M4-09-0736-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 22, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We had auth to put this medicine in this patients pump."

Amount in Dispute: $652.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Providers are required to use appropriate and proper billing codes in accordance with the Texas labor Code and Division rules. Moreover, in this case the revised EOR clearly advised the Requestor/Provider of the correct CPT code to use and they failed to submit any bills reflecting that code."

Response Submitted by: Jeffrey M Lust, 600 N Pearl, Suite 1450, LB 156, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2008	J2278	$652.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out requirements for medical bill submission by health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150 – Payer deems the information submitted does not support this level of service
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

Issues

1. Did the requestor submit the claim with applicable codes?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) (1) states, in pertinent part, "for coding, billing, reporting and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; …and other payment policies in effect on the date a service is provided…" Review of the documentation finds that submitted medical bill contained the HCPCS code J2278. The Medicare policy in effect for the dates of service in dispute may be found at http://www.cms.gov CMS Manual Publication 100-04 Medicare Claims Processing, Transmittal 2132 which states, in pertinent part, that the local contractor sets payment policies for J7799. At the time these services were rendered, the applicable billing instructions were found in the LCD for Implantable Infusion Pump, published by Trailblazer. Trailblazer instructed providers to bill in the following manner: "Note: Use J7799KD* to indicate compounded and/or combination drugs used in implantable infusion pumps including fluxuride, morphine sulfate, hydromorphone, fentanyl, compounded baclofen and ziconitide. Other drugs are not covered." According to the Medicare contractor's billing instructions, the medication should have been submitted with HCPCS code J7799KD. Reimbursement cannot be recommended as the medical bill did not meet the billing requirements of the applicable Medicare policy.

2. The requestors' medical bill did not meet requirements of instructions detailed in 28 Texas Administrative Code §134.203(b) (1). For that reason, payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		October 28, 2014

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.