



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

COMPREHENSIVE PAIN MANAGEMENT

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-10-4173-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MAY 25, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Physician saw the patient for an visit for a pump refill. Pump was filled with Morphine 600mg, Bupivacaine 100mg, Clonidine 2.5 mg, and Baclofen 2mg. Patient has an intraspinal pump surgically implanted inside of him which delivers medications to him intraspinally for pain relief. Per medicare, compound Baclofen (J7799KD) must be billed on a separate detail line from other J7799KD pain management drugs due to different limited coverage indications."

Amount in Dispute: \$1,501.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed HCPCS code J7799-KD for Morphine 600mg, Bupivacaine 100mg, and Clonidine 2.5mg on line three of its bill. The requestor on line five billed HCPCS code J7799-KD for 2mg of Baclofen. Texas Mutual paid the Baclofen but rolled it into the payment for J7799 on line three....The MAR, then, for the four compounded drugs is \$285.00. Granted Texas Mutual ought to have put a separate MAR amount on line five of the bill instead of consolidating the payment of line 3 and line 5 all to line 3. Certainly, this must have confused the requestor and led to the conclusion it had not been paid for the Baclofen when it had. In fact the requestor was overpaid, much overpaid. Given the above, Texas Mutual believes no further payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2010	Pain Pump Refill - HCPCS Code J7799 KD	\$1,501.00	\$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

- 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 217-The value of this procedure is included in the value of another procedure performed on this date.
 - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - 891-The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor support position that billing is in accordance with Medicare policy?
2. Is the requestor entitled to reimbursement?

Findings

1. HCPCS code J7799 is defined as “NOC drugs, other than inhalation drugs, administered through DME.”

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

Trailblazers Health Enterprises published an article titled “Part B Drugs Used in an Implantable Infusion Pump” in January 2009. This article provided coding guidelines that indicate that “...compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered.” This article goes on to state that “Compounded Baclofen (J7799KD) must be billed on a separate detail line of the claim from other J7799KD pain management drugs due to different limited coverage indications.” A review of the submitted medical bill supports the requestor’s position that HCPCS code J7799KD was billed in accordance with Medicare policy.

2. The respondent denied reimbursement for the disputed services based upon “426-Reimbursed to fair and reasonable.”

28 Texas Administrative Code §134.203 (d)(1) (2)and (3) states “The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

The Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Texas Medicaid fee schedule.

28 Texas Administrative Code §134.203 (f) states “For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).”

28 Texas Administrative Code §134.1(f) requires in pertinent part, that reimbursement shall: “(1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.”

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute

involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that reimbursement of \$1,501.00 is fair and reasonable.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that 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

_____	_____	<u>06/05/2014</u>
Signature	Medical Fee Dispute Resolution Officer	Date

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.