



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

RENSIMER & ASSOCIATES

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-11-1995-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

FEBRUARY 17, 2011  
FEBRUARY 18, 2011

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "A4305-This code paid by same carrier. In addition this is the drug delivery system which is medically necessary for IV Infusion Therapy Services. J0878-Medicare allows \$0.43 per unit. Workers comp should pay 125% which is \$0.54 per unit."

**Amount in Dispute:** \$549.12

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor lists the MAR as \$.54 per unit: 'Medicare allows \$.43 per unit. Workers' comp should pay 125% which is \$0.54 per unit.' (See requestor's DWC-60 packet.) Rule 134.203 at (d) states in part the MAR for J codes is determined in one of three ways:

- A. 125% percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. Texas Mutual reviewed the DMEPOS fee schedule. It contains no J codes at all. Therefore, A does not apply.
- B. If the code has no published Medicare rate, then 125% of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS. The Texas Medical fee schedule does not have a listed fee for code J0878.
- C. If neither A or B apply, then as calculated according to subsection (f) of this section provided by Rule 134.1...

Texas Mutual believes the MAR for the J code in question is the fair and reasonable reimbursement derived from Medicare's Drugs & Biologicals Fee Schedule for code J0878. Given this, 999 units of J0878 @ \$.43 equals \$429.00. This is the fair and reasonable reimbursement for 999 units. And 504 units of J0878 @ \$.43 equals \$216.72. This is the fair and reasonable reimbursement for 504 units. Texas Mutual paid in excess of fair and reasonable...The requestor billed code A4305...The requestor lists the MAR for this as \$42.84 and \$57.12 respectively. Texas Mutual denied inadvertently payment of code A4305."

**Response Submitted by:** Texas Mutual Insurance Co.

#### SUMMARY OF FINDINGS

| Dates of Service                 | Disputed Services                                 | Amount In Dispute             | Amount Due |
|----------------------------------|---|-------------------------------|------------|
| March 18, 2010<br>April 15, 2010 | HCPCS A4305 (4 units)<br>Syr/Needle Syringe 100cc | \$57.12/date<br>X2 = \$114.24 | \$0.00     |

|   |  |                               |        |
|---|--|-------------------------------|--------|
| March 22, 2010<br>April 5, 2010<br>April 12, 2010                   | HCPCS A4305 (3 units)<br>Syr/Needle Syringe 100cc        | \$42.84/date<br>X3 = \$128.52 | \$0.00 |
| March 18, 2010<br>March 22, 2010<br>April 5, 2010<br>April 12, 2010 | HCPCS Code J0878 (4500 units per date)<br>Daptomycin 1mg | \$45.00/date<br>X4 = \$180.00 | \$0.00 |
| April 8, 2010<br>April 15, 2010                                     | HCPCS Code J0878 (6000 units per date)<br>Daptomycin 1mg | \$63.18/date<br>X2 = \$126.36 | \$0.00 |
| TOTAL   |  | \$549.12                      | \$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 effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-W1-Workers compensation state fee schedule adjustment.
  - CAC-W3-Additional payment made on appeal/reconsideration.
  - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
  - CAC-217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (NOTE: To be used for workers' compensation only).
  - 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.
  - 284-No allowance was recommended as this procedure has Medicare status of 'B' (Bundled).
  - 426-Reimbursed to fair and reasonable.
  - 723-Supplemental reimbursement allowed after a reconsideration of services.
  - 724-No additional payment after a reconsideration of services.
  - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
4. The requestor submitted five dispute packets, (three on February 17, 2011 and two on February 18, 2011), for the disputed services listed above that were consolidated into one dispute.

#### **Issues**

1. Is the value of HCPCS code A4305 included in the value of another service rendered on the disputed date of service? Is the requestor entitled to reimbursement for HCPCS code A4305?
2. Is the requestor entitled to additional reimbursement for HCPCS code J0878?

#### **Findings**

1. According to the explanation of benefits, the respondent denied reimbursement for HCPCS code A4305 based upon unbundling. On the disputed dates of service, the requestor billed for an office visit code 99213 or 99214, and a variation of HCPCS codes: 99070, A4221, A4305, A4209, J1642, J3490, J0878, A4649, and A6454.

28 Texas Administrative Code §134.203(b)(1), states "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; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

HCPCS code A4305 is a status "P= Bundled/excluded codes." Per Medicare policy "There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee

schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident.

The Division finds that the disputed HCPCS code A4305 is incidental to the physician service rendered on the disputed dates of service; therefore, the value of HCPCS code A4305 is bundled. As a result, no reimbursement is recommended.

2. Per 28 Texas Administrative Code §134.203(d) "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."

To determine the MAR the Division considered the following:

- A review of the Medicare 2010 DMEPOS fee schedule finds that HCPCS code J0878 does not have a fee schedule.
- Texas Medicaid fee schedule for HCPCS code J0878 is \$0.38; therefore, per 28 Texas Administrative Code §134.203(d)(2),  $\$0.38 \times 125\% = \$0.47$ .
- The total number of units of HCPCS code J0878 billed on the disputed services is 30,000; therefore,  $30,000 \times \$0.47 = \$14,100.00$ . The respondent paid \$15,893.64. As a result, additional reimbursement is not 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

06/26/2014  
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.**