



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RAUL G. MARTINEZ, MD

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-15-3494-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JUNE 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We content that ESIS Medbill Impact did not apply the 28 Texas Administrative Code Rules and Guidelines when auditing the compound drug of Morphine and Bupivicane. All the ESIS Medbill Impact denials cite the invalid NDC billed. As we have explained on all appeals that compound drugs do not have one NDC but we did enclose the pharmacy record of the compound drugs."

Amount in Dispute: \$460.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$0.00. Bupivacaine NDC #51927-2358-01 is not a valid NDC # in either Redbook or Medi-Span. For this reason, we are not able to calculate a payment for this compound drug."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 5, 2014, Pain Pump Refill - HCPCS Code J7799 KD, \$460.00, \$75.00

FINDINGS AND DECISION

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

Background

- 1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 Texas Register 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline 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:
  - DCN 9250209 Invalid NDC 51927235801.
  - 148-This procedure on this date was previously reviewed.
  - ANSI18-Duplicate claim/service.
  - Please provide us with the NDC#, Dosage Metric Decimal Units, Dosage Form, Route of Administration and the Number of Containers for each component of this Compound Drug along with a copy of the bill for our review.
  - Need ndc; mor/bupi.
  - 193-Original payment decision is being maintained. This claim was processed properly the first time.
  - CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.
  - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

## Issues

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

## Findings

1. The respondent denied reimbursement for the disputed services based upon “DCN 9250209 Invalid NDC 51927235801.”

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

Medicare’s Texas Medicare Administrative Contractor, Novitas Solutions, published an article titled Part B Compounded Drugs Used in an Implantable Infusion Pump, effective December 1, 2013, which states “Compounded Drugs used in an implantable infusion pump must be billed using the Not Otherwise Classified Code (NOC) J7799KD, whether a single drug or a combination of drugs is administered. Some compounded drug descriptions are similar to Average Sales Price (ASP) HCPCS codes (e.g., code J2275 for preservative-free non-compounded morphine). Do not use these codes when submitting claims for reimbursement. (Note: The ASP drug files are not used in pricing compounded drugs.) The claim must be filed with code J7799KD.” 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. 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.”

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.”

Per 2014 NCCI Policy Manual for Medicare Services, Chapter 12, (A) “The HCPCS Level II codes are alphanumeric codes developed by the Centers for Medicare and Medicaid Services (CMS) as a complementary coding system to the *CPT Manual*. These codes describe physician and non-physician services not included in

the *CPT Manual*, supplies, drugs, durable medical equipment, ambulance services, etc.” HCPCS code J7799 is a HCPCS Level II code. Therefore, the guidelines outlined in 28 Texas Administrative Code §134.203(d)(1-3) apply to the disputed service.

28 Texas Administrative Code §134.203(d)(1) 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.”

HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule.

28 Texas Administrative Code §134.203(d)(2) states, “ 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.”

HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule.

28 Texas Administrative Code §134.203(d)(3) which states “if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

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, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(f) which states that “Fair and reasonable 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)(O) states the request for dispute resolution shall include: “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.” Review of the submitted documentation finds that the requestor did not document, discuss, demonstrate or justify the amount sought of \$426.00 would be fair and reasonable in accordance with §134.1; however a copy of an invoice that indicates a cost of \$75.00 for Morphine/Bupivacaine was included in the dispute packet. The Division finds that the requestor supported that payment of \$75.00 would be a fair and reasonable rate of reimbursement for HCPCS code J7799-KD. As a result, payment of \$75.00 is recommended.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$75.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$75.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	_____	07/16/2015
Signature	Medical Fee Dispute Resolution Officer	Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request 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 §141.1(d).

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