TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS KNEE AND SPORTS MEDICINE

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-16-3148-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "J7324 is allowed and paid separately by Medicare. These were not paid correctly according to the Medicare fee schedule and guidelines."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2015 and July 1, 2015	Hyaluronan — Procedure code: J7324	$650.00	$0.00

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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged June 23, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier has not responded. Accordingly, this decision is based on the information available at the time of review.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B887 – This is a bundled or non covered procedure based on Medicare PFS guidelines; no separate payment allowed.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied payment for the disputed services with claim adjustment reason code B887 – "This is a bundled or non covered procedure based on Medicare PFS guidelines; no separate payment allowed." 28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers . . . and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the submitted information finds that, per Medicare billing and payment policies, HCPCS code J7324 has a payment status indicator of "E"—denoting codes that are excluded from coverage under the Medicare Physician Fee Schedule by regulation. Medicare does permit its intermediaries to consider payment at carrier discretion. If reimbursement is justified, these services are paid at a fair and reasonable rate.

   The insurance carrier's payment reduction reason is supported.

2. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(f), which requires that 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).

   The general payment provisions of 28 Texas Administrative Code §134.1(e) requires that in the absence of an applicable fee guideline or a negotiated contract, Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in §134.1(f).

   28 Texas Administrative Code §134.1(f) requires 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.

   Review of the submitted information finds that the requestor did not explain how the requested reimbursement meets the requirements of §134.1(f).

   Moreover, 28 Texas Administrative Code §133.307(c)(2)(M) requires the requestor to submit copies of all applicable medical records related to the services in dispute.

   Review of the submitted information finds insufficient medical documentation to support the services as billed.

   The Division concludes that the submitted information does not support the additional reimbursement requested by the health care provider.

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 on 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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 5, 2016
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.