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
THE WELLNESS CORNER, LLC

Respondent Name
TEXAS DEPARTMENT OF TRANSPORTATION

MFDR Tracking Number
M4-17-1316-01

Carrier's Austin Representative
Box Number 32

MFDR Date Received
January 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim is for compounded medication used in an implanted infusion pump in the physician office. Due to medication containing pharmaceuticals in dosage forms and combinations that are not commercially available, the claim needs to be manually processed. The claim should be process with the NDC NUMBER AND THE UNITS NOT THE PROCEDURE CODE. SHOULD BE PROCESS UNDER MEDICAL NOT PHARMACY."

Amount in Dispute: $67,550.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The reimbursement was based upon the Medicare Local Coverage Determination (LCD) 'Implantable Infusion Pump-M24' for coverage indications for drugs administered through an implanted infusion pump. The conversion factor is applied of 125% so for over 4oMG of Morphine is $60.00 times 125% reimbursing the amount at $75.00."

Response Submitted by: WellComp Managed Care Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 25, 2016 to September 8, 2016	Compound medication refill of implanted infusion pump, performed in physician office	$67,550.00	$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 §102.4 establishes certain rules for non-Commission communications.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

4. 28 Texas Administrative Code §134.1 sets forth general provisions regarding medical reimbursement.
5. 28 Texas Administrative Code §134.203 sets out the division's fee guideline for professional medical services.
6. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
7. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
8. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
9. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - W3 – Reporting purposes
   - 29 – THE TIME LIMIT FOR FILING HAS EXPIRED.

Issues

1. Were the services timely billed to the insurance carrier?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for date of service September 8, 2016 with reason code 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED."

   28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   Although Texas Labor Code §408.0272 provides certain exceptions to the above timely filing deadline, review of the submitted information finds none of those exceptions apply to the circumstances in this dispute.

   28 Texas Administrative Code §102.4(h) states that, unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

   (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

   The 95th day following the date of service was December 12, 2016. The insurance carrier's EOB indicates the carrier received that bill on December 27, 2016. The date five days prior to the date of receipt was December 22, 2016, a Thursday, which was not listed as a legal holiday in 2016. This is still ten later than the 95th day deadline. The signature date on the submitted bill is December 19, 2016; however this date is also after the timely filing deadline.

   The preponderance of the evidence supports the insurance carrier's position that the bill for service date September 8, 2016 was submitted more than 95 days following the date of service. As such, the provider exceeded the timely filing limit for submitting the medical bill. Consequently, the division finds the health care provider has forfeited the right to reimbursement for that bill, pursuant to Labor Code §408.027(a).

2. This dispute regards reimbursement for a compounded medication used in refilling an injured employee's implanted infusion pump, billed using HCPCS code J7799-KD. The refill services were performed in a physician office setting.

   HCPCS code J7799-KD is a general code for non-inhalation drugs administered by means of durable medical equipment. The health care provider included additional descriptions on the claims indicating the specific combination of drugs (or compound), including the NDC number for each drug. The active ingredient is morphine, and the other two billed components are sterile water and sodium chloride for sterile injections.

   HCPCS code J7799 has payment status code E, indicating that the services are excluded from Medicare's Physician Fee Schedule (PFS) by regulation. CMS does not determine a price or relative value for this service and no payment is made under the PFS. Payment, when covered under Medicare, is determined at contractor discretion according to a reasonable charge.

   In the Texas Worker's Compensation system, under the division's *Medical Fee Guideline for Professional Services*, Rules §134.203(f) and (h) require that when neither Medicare nor Texas Medicaid assigns a relative value or price for a service, in the absence of an established MAR or a negotiated or contracted amount complying with Labor Code §413.011, reimbursement shall be the least of the health care provider's usual and customary charge or a fair and reasonable amount consistent with Texas Administrative Code §134.1.

   Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which 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 Rule §134.1(f).

3. In the following analysis, the information presented by each party to support their position regarding the fair and reasonable payment amount is examined to determine which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in dispute.

   The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

   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.

   The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004).

   Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

   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. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide:

> 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) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

The division will first review the information presented by the requestor to determine whether it has met the burden to show that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, then the division will review the respondent's evidence.

Review of the submitted documentation finds that:

- The requestor does not explain or indicate a particular method for how payment should be calculated.
- The requestor's *Table of Disputed Services* indicates that the amount in dispute is the same as the billed charge for each service.
- The health care provider did not explain how their billed charges are determined.
- The division has previously found that a charge-based reimbursement methodology using a provider's billed charges or a percentage of billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the division in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  > this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

  While a physician's office is not a hospital, similar concerns apply here. Thus, a reimbursement amount calculated based on a provider's billed charge cannot be favorably considered when no other data or documentation is submitted to support the fairness and reasonableness of the payment amount sought.
- The requestor did not explain or provide documentation to support how the requested payment amount ensures the quality of medical care to injured employees.
- The requestor did not explain or provide documentation to support how the requested payment amount achieves effective medical cost control.
- The requestor did not explain or provide documentation to support how the requested payment amount ensures similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not explain or provide documentation to support that the requested payment amount is consistent with the criteria of Labor Code §413.011.
- The requestor did not explain or provided documentation to support that the requested payment amount satisfies the requirements of Rule §134.1.

The request for additional reimbursement is not supported. After thorough review of the submitted information, the division concludes the requestor has failed to discuss, demonstrate, and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

The applicable guideline for determining reimbursement of the disputed infusion pump refill supplies and services is found in 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

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

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 26, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
	Martha Luévano	May 26, 2017
Signature	Director of Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *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. **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.