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

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Center for Pain Relief, P.A.

Respondent Name
Twin City Fire Insurance Company

MFDR Tracking Number
M4-18-4583

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim was billed with Code J7999 KD and the carrier did not process the code when our claim was originally submitted. We sent a reconsideration request to the carrier requesting reprocessing of … Code J7999 KD. The carrier responded with payment for Code 62369 and still did not include or process Code J7999 KD. Please review the attached MDR request and determine Code J7999 KD has not processed, and no payment has been issued for this code."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Sedgewick, Twin City Fire Insurance Company's agent was notified of this medical fee dispute on August 31, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. Per 28 Texas Administrative Code §133.307(d)(1), if a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.

No response has been received from Sedgwick or Twin City Fire Insurance Company to date. For that reason, the decision will be based on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 15, 2018	J7999-KD	$500.00	$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. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

1. The requestor billed the insurance carrier $500.00 for HCPCS Code J7999-KD rendered on March 15, 2018. The insurance carrier denied the disputed services with denial reduction code, "P12 – Workers' compensation jurisdictional fee schedule adjustment."

   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."

   The item in dispute is a compounded drug to refill an implantable spinal infusion pump. Review of the medical bill finds that the provider billed with the correct HCPCS code J7999. The insurance carrier did not respond to the MFDR DWC60 request. The Texas Department of Insurance, Division of Workers' Compensation (DWC) found insufficient information to support the insurance carrier's denial reason. Accordingly, the DWC will review the disputed charges pursuant to the applicable rules and guidelines.

2. The general payment provisions of 28 Texas Administrative Code §134.1 require 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).

   The Medicare Physician Fee Schedule does not determine a price or relative value for HCPCS J7999 service date March 15, 2018. Texas Administrative Code §134.1(f) requires that fair and reasonable reimbursement shall:

   - Be consistent with the criteria of Labor Code §413.011;
   - Ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   - Be based on nationally recognized published studies, published DWC 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* 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* 104 (Texas Appeals – Austin 2003, petition for review denied), that "each … 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 … 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 information finds that the requestor did not discuss, demonstrate, or justify how the requested reimbursement meets the requirements of §134.1(f). The requestor has failed to support that the requested payment would result in a fair and reasonable reimbursement for the services in dispute.

The DWC finds that the requestor has not established that reimbursement is due. As a result, reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care, the role of the DWC is to adjudicate the payment, given the relevant statutory provisions and DWC rules. The DWC would like to emphasize that the outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent to MFDR. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the DWC 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 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

	Laurie Garnes	November 1, 2018
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 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.