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
Center for Pain Relief

Respondent Name
Insurance Co of the State of Pa

MFDR Tracking Number
M4-19-4925-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 19, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the information attached to support the covered billing of code J7999 KD and determine the carrier denied payment in error."

Amount in Dispute: $49.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2019	J7999-KD	$49.20	$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 §134.503 sets out the pharmacy fee guideline.
4. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
5. Texas Labor Code §413.011 sets out general provisions regarding reimbursement policies and guidelines.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing errors

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the insurance carrier $500.00 for HCPCS Code J7999-KD rendered on January 29, 2019. The insurance carrier denied the service stating claim lacked information required for processing specifically, an NDC (National Drug Code). 28 TAC §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 medical bill finds that the provider billed with the correct HCPCS code J7999 - "NOC drugs, other than inhalation, administered through DME." DWC will review the disputed charges based on the applicable DWC rules and guidelines.

2. The Division's *Pharmacy Fee Guideline*, at 28 TAC §134.503(a)(2), states that "This section does not apply to parenteral drugs." While not specifically defined in the rule, "parenteral" is understood to mean a drug whose route of administration is other than by means of the alimentary canal (that is, not oral or suppository). Drugs that are infused or implanted would fall under the "parenteral" exception and are not covered by the *Pharmacy Fee Guideline*.

   The applicable fee guideline is found in 28 TAC §134.203(d) which states,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   > (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.

   Review of the Medicare DMEPOS fee schedule found no allowable nor was an allowable found in the Texas Medicaid fee guideline.

   28 TAC §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).

   Based on the above, the fee guideline is discussed below.

3. The general payment provisions of 28 TAC §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).

   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.

   28 Texas Administrative Code §133.307(c) (2) (E) (v)

   > documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a 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.

Conclusion

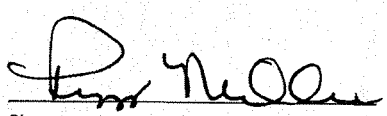
In resolving disputes regarding the amount of payment due for health care, the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules. The Division would like to emphasize that the outcome of this medical fee dispute relied upon the evidence presented 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 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



Signature

Peggy Miller
Medical Fee Dispute Resolution Officer

September 25 2019
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.