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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA, MD

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-20-0510-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 23, 2019

REQUESTOR'S POSITION SUMMARY

"The carrier has reduced this claim inappropriately and not in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $241.00

RESPONDENT'S POSITION SUMMARY

"The bill for DOS 5/21/19 has been reviewed and no additional payment is due as the bill was priced correctly per pricing logic below."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2019	CPT Code 20610-RT	$0.00	$0.00
	CPT Code 77002-26	$0.00	$0.00
	HCPCS Code J3301	$241.00	$2.40
Total		$241.00	$2.40

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2912, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason code(s):
    - P12-Description not listed.
    - 309-The charge for this procedure exceeds the fee schedule allowance.
    - B13-Description not listed.
    - 193-Description not listed.
    - W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for HCPCS Code J3301?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $241.00 for HCPCS code J3301 rendered on May 21, 2019.
2. The fee guidelines for professional services is found in 28 TAC §134.203.
3. 28 TAC §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 TAC §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."

   HCPCS Code J3301 is described as "Injection, triamcinolone acetonide, not otherwise specified, 10 mg." The requestor billed 20 units of J3301.

   The respondent paid $40.00 for J3301 based upon the fee guideline.

4. To determine the MAR for HCPCS cod J3301 the DWC refers to 28 TAC §134.203(d)(1).

   28 TAC §134.203(d) 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;

   (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.

   The DWC finds:

   - Per the DMEPOS fee schedule HCPCS code J3301 does not have a published Medicare rate.
   - Per Texas Medicaid, code J3301 has a fee schedule of $1.70.
   - Per 28 TAC §134.203(d), the MAR is y 125% of the Medicaid rate. Therefore, $1.70 X 125% = $2.12 X 20 units = $42.40.
   - The respondent paid $40.00.
   - The requestor is due the difference between the MAR and amount paid of $2.40.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2.40.

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 DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $2.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/14/2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR 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 DWC. **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.