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
CENTER FOR PAIN RELIEF, PA

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-20-2256-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 13, 2020

REQUESTOR'S POSITION SUMMARY

"The carrier owes this provider payment for his service and we have submitted all of the necessary documents to support the service."

Amount in Dispute: $49.20

RESPONDENT'S POSITION SUMMARY

"Supplemental response will be provided once the bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2019	HCPCS Code J7999KD	$49.20	$49.20

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, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.503, effective October 23, 2011, sets out the guideline for medical services, charges and payment of pharmacy services.
3. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
4. 28 TAC §134.1, effective March 1, 2008, sets out general provisions regarding medical reimbursement.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16-Claim service lacks information or has submission billing errors.
   - W3-Request for reconsideration.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for HCPCS code J7999KD rendered on November 7, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $49.20 for HCPCS code J7999-KD rendered on November 7, 2019.
2. HCPCS code J7999 is described as "Not otherwise classified (NOC) drugs, other than inhalation drugs, administered through durable medical equipment (DME)." The modifier -KD is appended to J7999, to indicate infused through DME.
3. The insurance carrier denied reimbursement for HCPCS code J7999-KD based upon code: 16 (defined above). The requestor submitted documentation to support billing HCPCS code J7999-KD; therefore, the respondent's denial of payment is not supported.
4. The DWC's Pharmacy Fee Guideline found at 28 TAC §134 503(a)(2), states, "This section does not apply to parenteral drugs". Drugs that are infused or implanted would fall under the parenteral exception and are not covered by the Pharmacy Fee Guideline.
5. The fee guidelines for disputed services is found at 28 TAC §134.203.
6. 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."
7. 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."
8. 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.

   A review of the DMEPOS and Texas Medicaid fee schedule does not list HCPCS code J7799KD; therefore, 28 TAC §134.203(f) applies.
9. 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).
10. 28 TAC §133.307(c)(2)(o) states,
    Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.

    Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: 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) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable.

11. The requestor submitted a copy of a bill and explanation of benefits for date of service June 19, 2019 that support respondent issued payment in the amount of $49.20 for HCPCS code J7999KD; therefore, the DWC finds the requestor has supported that payment of $49.20 is fair and reasonable.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $49.20.

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 $49.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/24/2020 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.