TDI Division of Workers' Compensation
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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
M4-24-0507-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 1, 2023	J7999 KD	$42.57	$0.00
March 29, 2023	J7999 KD	$42.57	$0.00
	Total	$85.14	$0.00

Requestor's Position

"The carrier denied payment of Code J7999 KD stating, 'documentation does not include the radiology results.' We sent a reconsideration to the carrier stating there are no radiology results. There is no radiology involved with this code. We have provided all of the necessary documentation for these codes to be paid."

Amount in Dispute: $85.14

Respondent's Position

The Austin carrier representative for Insurance Co of the State of PA is Flahive, Ogden and Latson. The representative was notified of this medical fee dispute on November 7, 2023.

Per 28 TAC §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.503 sets out the pharmacy fee guidelines.
3. 28 TAC §134.1 defines medical reimbursement policies.
4. Texas Labor Code §413.011 sets out the requirements of fair and reasonable documentation.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- TX790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- XXC86 – Documentation does not include the radiology results.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
- 93 – No claim level adjustments.

Issues

1. Is the respondent's denial supported?
2. What rule is applicable to reimbursement?
3. Did the requestor meet the requirements of determining requested amount was fair and reasonable?

Findings

1. The insurance carrier denied code J7999 -KD for dates of service March 1, 2023 and March 29, 2023 with denial reason code, "XXC86 – Documentation does not include the radiology results." Review of the submitted information included with this request for MFDR indicates the services are compounded medication administered via syringe into an intrathecal catheter. No radiological services were rendered. The insurance carrier's denial is not supported.
2. The requestor is seeking reimbursement of Code J7999 -KD, Compounded drug NOC. Review

of the submitted "Medtronic" Patient report indicates this compounded medication was for a refill of a pain pump.

DWC Rule 28 TAC §134.503 titled Pharmacy Fee Guideline states in part that "(a)(2) This section does not apply to parenteral drugs." Parenteral drugs are drugs that are administered by routes other than the digestive tract. The disputed service is a parenteral drug and therefore TAC §134.503 does not apply.

DWC Rule 28 TAC §134.1 (e) states, Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

- the Division's fee guidelines;
- a negotiated contract; or
- in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

Based on Rule §134.503 (a)(2) the DWC pharmacy guidelines do not apply to this type of pharmacy services.

As stated above, the Division's fee guidelines do not apply, and insufficient evidence was found to support a negotiated contract that exists between the two parties. Therefore, reimbursement is calculated under the fair and reasonable method as shown below.

DWC Rule 28 TAC §134.1 (f) states, 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 Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

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."

DWC Rule 28 TAC §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 DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

3. Review of the submitted documentation finds the following:

- The requestor did not submit documentation to substantiate that the billed charges for disputed services represent a fair and reasonable rate of reimbursement. A health care provider's usual and customary charges are not evidence of a fair and reasonable rate of what insurance companies are paying for the same or similar services.

- Payment of the provider's billed charge is thus not acceptable when it leaves the payment amount in the health care provider's control — which would ignore the 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.

- Accordingly, the use of a health care provider's "usual and customary" charges cannot be favorably considered unless other data or documentation is presented to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support how the requested payment would ensure the quality of medical care and achieve effective medical cost control.

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 TAC §134.1.

The requestor has failed to meet the requirements of DWC rules and the Labor Code. The requestor has the burden of proof at MFDR to support their request for additional reimbursement by a preponderance of the evidence. DWC concludes the requestor provided insufficient information to meet that burden. Consequently, payment cannot be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 2, 2024 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.