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 and Address

MANUEL RAMIREZ MD
CENTER FOR PAIN RELIEF PA
4275 LITTLE ROAD SUITE 202
ARLINGTON TX 76016

Respondent Name
CONTINENTAL CASUALTY CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-1449-01

MFDR Date Received
FEBRUARY 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of Code J7799KD for all of the dates of service listed above. The carrier denied reimbursement for the code as billed."

Amount in Dispute: $1,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor seeks reimbursement for medication refills for an infusion pump. The medication is morphine. Requestor billed as a compounded medication under CPT J7799. However, the billing form does not appear to have been correctly completed. Carrier denied the submitted bill as the 'procedure code/modifier was invalid'. Box 19 lists the dosage as 'Morphine Sulfate 20mg-20ml pump.' The Trailblazer memorandum attached to Requestor's DWC-60 indicates that dosage information must be provided in 'megs or mgs only.' The assigned reimbursement for morphine up to 45ml is $40. Requestor has not provided dosage information and is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2012 September 12, 2012	CPT Code J7799-KD	$500.00/day	$1,000.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 181-Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
   - QA-The amount adjusted is due to bundling or unbundling of services.
   - SRS337-Please submit a manufacturers invoice for this item and a copy of the bill for our review.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - PI-These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patient's responsibility, unless the workers compensation state law allows the patient to be billed.

Issues

1. Did the requestor support billing of J7799-KD was in accordance with Medicare policy?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position summary that "Requestor seeks reimbursement for medication refills for an infusion pump. The medication is morphine. Requestor billed as a compounded medication under CPT J7799. However, the billing form does not appear to have been correctly completed. Carrier denied the submitted bill as the 'procedure code/modifier was invalid'."

   HCPCS code J7799 is defined as "NOC drugs, other than inhalation drugs, administered through DME."

   Trailblazers Health Enterprises published an article titled "Part B Drugs Used in an Implantable Infusion Pump" in October 2011. This article provided coding guidelines that indicate that "…compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered." A review of the submitted medical bill supports the requestor's position that HCPCS code J7799KD was billed in accordance with Medicare policy.

2. 28 Texas Administrative Code §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 Texas Administrative Code §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."

   28 Texas Administrative Code §134.203 (d)(1) (2)and (3) 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 Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Medicaid rate.

   28 Texas Administrative Code §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)."

   28 Texas Administrative Code §134.1(f) requires in pertinent part, that 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."

   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. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G) effective May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the 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 Division has not established a maximum allowable reimbursement (MAR), as applicable."

28 Texas Administrative Code §133.307(o) effective June 1, 2012 states "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."

Review of the submitted documentation finds that:

- The requestor submitted copies of explanation of benefits for the same injured employee that support position that the respondent paid $500.00 for CPT code J7799-KD on May 19, 2010, September 15, 2010, November 10, 2010, January 5, 2011, and January 25, 2012.
- The request for reimbursement of $500.00 per day = $1,000.00 is supported. Thorough review of the documentation submitted by the requestor finds that the requestor has demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,000.00.

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 Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,000.00 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	2/28/2014 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 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 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 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.