



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

University OH Partners

Respondent Name

Texas A & M University System

MFDR Tracking Number

M4-16-2474-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

April 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The submitted documentation includes the receipt paid by my practice to the laboratory for the testing and receipt for Fedex for shipping to the laboratory. Documentation is also provided of the fee previously agreed upon by another group in the University for surveillance testing. This was the exact same fee charged to Workers' Compensation which was severely reduced."

Amount in Dispute: \$288.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOB created for the MDR M4-16-2474-01. After review it appears the previous audits did not enter the number of units correctly therefore not allowing payment. Audit attached allowing additional monies totally \$60.51 for the 3 units."

Response Submitted by: Well Comp

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 15, 2015, 88638 (4), \$288.53, \$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 reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment
  - W3 – Additional reimbursement made on reconsideration
  - 193 – Original payment decision is being maintained

**Issues**

1. What is the rule applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. 28 Texas Administrative Code §134.203(e) states in pertinent part,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

The maximum allowable reimbursement will be calculated as follows:

Date of Service	Submitted code	Units	Allowable	MAR Calculation	Carrier Paid
October 15, 2015	86638	4	\$11.13	$\$11.13 \times 125\% \times 4 =$ \$55.64	\$20.17 - 12/27/2015 \$60.51 – 5/3/2016
			Total		\$80.68

2. The maximum allowable reimbursement for the service in dispute is \$55.64. The carrier previously paid \$80.68. No additional reimbursement is recommended.

**Conclusion**

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 upon 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

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
June , 2016  
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.**