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
Texas Health Plano

Respondent Name
TX Assoc of Counties RMP

MFDR Tracking Number
M4-18-4775-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The maximum allowable reimbursement for all laboratory/pathology services is 200% of Medicare. Laboratory rates are based on Medicare's clinical lab schedule. Hospital (outpatient and inpatient) laboratory rates are based on 200% of the national clinical lab schedule."

Amount in Dispute: $60.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The "Q4" status indicator was created to identify 13X bill type claims where there are only laboratory HCPCS codes that appear on the Clinical Laboratory Fee Schedule (CLFS), automatically change their status indicator to "A," and pay them separately at the CLFS payment rate."

Response Submitted by: Careworks

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 8, 2018	Outpatient Laboratory Services	$60.52	$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 §134.403 sets out the reimbursement guidelines for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

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

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What rule is applicable to reimbursement?

Findings

1. The requestor is seeking $60.52 for clinical laboratory services performed in an outpatient hospital setting. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 Texas Administrative Code §134.403 (d) and (h) state in pertinent parts,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided
   >
   > For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

   The OPPS reimbursement formula factors are found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. The specific factor is the Status Indicators. The status indicator for each of the HCPCs code listed on the DWC060 have a "Q4" status indicator which is defined as, "(2) In other circumstances, laboratory tests should have an SI=A and payment is made under the CLFS."

   Based on the requirements of 28 Texas Administrative Code 134.403 (h) the applicable Division fee Guideline is found in 28 Texas Administrative Code §134.203 (e). The calculation is found below.

2. 28 Texas Administrative Code 134.203 (e) states,

   > 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.

   Review of the 2018 Clinical Diagnostic Laboratory Fee Schedule found at www.cms.gov, finds there is no professional component for the services in dispute. The maximum allowable reimbursement will be calculated based on 134.203(1) as follows:

Billed Code	Allowable	MAR (Allowable x 125%)	Carrier Paid	Additional payment amount
36415	$3.00	$3.75	$5.44	$0.00
80053	$13.04	$16.30	$16.30	$0.00
85027	$7.98	$9.98	$9.98	$0.00
85610	$4.85	$6.06	$6.06	$0.00
85652	$3.33	$4.16	$4.16	$0.00

85730	$7.42	$9.28	$9.28	$0.00
87641	$43.33	$54.16	$54.16	$0.00
		Total	$105.38	$0.00

The carrier's reduction is supported, no additional payment 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 28, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.