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 FORT WORTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-0756-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 12, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/denied APC."

Amount in Dispute: $302.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due for lab services provided to the claimant…"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 22, 2018	Outpatient Diagnostic Laboratory Services	$302.59	$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 hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What is the recommended payment for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards diagnostic laboratory services performed in an outpatient facility. Medicare's Outpatient Prospective Payment System (OPPS) assigns status indicator Q4 for conditionally packaged laboratory services. Payment for these items is ordinarily included in the facility payment for any other service on the bill assigned status J1, J2, S, T, V, Q1, Q2 or Q3. However, Medicare policy regarding packaged laboratory services (see *Medicare Claims Processing Manual* Chapter 4, §10.4.C.5) requires if a facility bills only Q4 services—without any codes assigned status indicators above—the Q4 status is changed to "A" (services paid by fee schedule other than OPPS). Services are then reimbursed subject to Medicare Clinical Laboratory Fee Schedule rates.

   DWC *Hospital Facility Fee Guideline* Rule §134.403(h) requires if Medicare reimburses using other fee schedules, the service is paid according to the division guideline applicable to the code on the date of service. DWC *Medical Fee Guideline for Professional Services* Rule §134.203(e)(1) requires that for pathology and laboratory services billed by a facility, the maximum allowable reimbursement (MAR) shall be 125% of the fee listed in the Medicare Clinical Fee Schedule for the technical component of the service. Reimbursement is calculated as follows:

   - Procedure code 36415 has a Medicare Clinical Laboratory fee of $3.00. 125% of this amount is $3.75
   - Procedure code 87389 has a Medicare Clinical Laboratory fee of $29.73. 125% of this amount is $37.16
   - Procedure code 87522 has a Medicare Clinical Laboratory fee of $52.88. 125% of this amount is $66.10
   - Procedure code 87902 has a Medicare Clinical Laboratory fee of $317.84. 125% of this amount is $397.30

2. The total MAR (maximum allowable reimbursement) for the services in dispute is $504.31. The insurance carrier paid $504.31, leaving an amount due to the requestor of $0.00. No additional payment is recommended.

Conclusion

The division emphasizes that the findings in this decision are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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

	Grayson Richardson	November 2, 2018
Signature	Medical Fee Dispute Resolution Officer	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.

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 form's instructions. The division must receive the request within twenty days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the division, using the contact information listed on the form, or to the field office handling the claim.

The party seeking review must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Include a copy of this *Medical Fee Dispute Resolution Findings and Decision*** together with any other information required by 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.