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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
CHUBB INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-0894-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 16, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $11.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor was reimbursed pursuant to the Medicare fee guidelines"

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
May 9, 2018	Outpatient Hospital Laboratory Services	$11.93	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - P300 – The amount paid reflects a fee schedule reduction.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Request for reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards outpatient facility services subject to DWC's *Hospital Facility Fee Guideline*, Rule §134.403, requiring the maximum allowable reimbursement (MAR) to be the Medicare facility specific amount applying Medicare Outpatient Prospective Payment System (OPPS) formulas and factors published in the Federal Register, as modified by DWC rules. Rule §134.403(f)(1) requires the Medicare facility specific amount and any outlier payment be multiplied by 200% for the disputed facility services.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 87070 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 87205 has status indicator Q4, for packaged labs; reimbursement is included with payment for the primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

Review of the submitted bill finds that the packaged labs were not the only services billed. These lab services are therefore packaged as component services of visit code 99204 billed for the same date.

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 30, 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 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.