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
BROWNWOOD REGIONAL MEDICAL CENTER

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

MFDR Tracking Number
M4-19-2222-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position statement for review.

Amount in Dispute: $144.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider was reimbursed … $227.95…. The reimbursement was in accordance with the Medical Fee Guidelines."

Response Submitted by: Flahive, Odgen & Latson, Attorneys at Law, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 23, 2018	Outpatient Hospital Diagnostic Laboratory Services	$144.67	$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.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issue

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards diagnostic laboratory services. Payment is subject to DWC's Professional Fee Guideline, Rule §134.203(e)(1), the facility fee is the Medicare Clinical Laboratory fee multiplied by 125%.

Reimbursement for the disputed services 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 80053 has a Medicare Clinical Laboratory fee of $13.04. 125% of this amount is $16.30
- Procedure code 82570 has a Medicare Clinical Laboratory fee of $6.39. 125% of this amount is $7.99
- Procedure code 82607 has a Medicare Clinical Laboratory fee of $18.61. 125% of this amount is $23.26
- Procedure code 82728 has a Medicare Clinical Laboratory fee of $16.83. 125% of this amount is $21.04
- Procedure code 82746 has a Medicare Clinical Laboratory fee of $18.15. 125% of this amount is $22.69
- Procedure code 83540 has a Medicare Clinical Laboratory fee of $7.99. 125% of this amount is $9.99
- Procedure code 83550 has a Medicare Clinical Laboratory fee of $10.79. 125% of this amount is $13.49
- Procedure code 83735 has a Medicare Clinical Laboratory fee of $8.27. 125% of this amount is $10.34
- Procedure code 83970 has a Medicare Clinical Laboratory fee of $50.96. 125% of this amount is $63.70
- Procedure code 84100 has a Medicare Clinical Laboratory fee of $5.85. 125% of this amount is $7.31
- Procedure code 84156 has a Medicare Clinical Laboratory fee of $4.53. 125% of this amount is $5.66
- Procedure code 84550 has a Medicare Clinical Laboratory fee of $5.58. 125% of this amount is $6.98
- Procedure code 85025 has a Medicare Clinical Laboratory fee of $9.59. 125% of this amount is $11.99
- Procedure code 81003 has a Medicare Clinical Laboratory fee of $2.77. 125% of this amount is $3.46

The total recommended reimbursement for the disputed services is $227.95. The insurance carrier provided documentation to support total payment of $227.95. Additional payment is not 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

	Grayson Richardson	January 25, 2019
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.