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 OF STEPHENVILLE

Respondent Name
XL INSURANCE AMERICA, INC.

MFDR Tracking Number
M4-19-3363-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Underpaid/Denied Lab Charge"

Amount in Dispute: $22.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rule is to only allow the technical component for radiology and pathology codes, on outpatient bills in TX. Hospitals should not be reimbursed for the total component, the provider appears to be seeking both the technical and professional component for pathology code 87389. 36415 has been reimburse at the total component, for the blood draw."

Response Submitted by: Coventry/Aetna

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
November 29, 2018	Outpatient Hospital Services	$22.86	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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.
   - Z652 - RECOMMENDATION OF PAYMENT HAS BEEN BASED ON THIS PROCEDURE CODE, (36415/87389) WHICH BEST DESCRIBES SERVICES RENDERED.
   - P300 – THE AMOUNT PAID REFLECTS A FEE SCHEDULE REDUCTION.
   - Z710 - THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
   - W3 – REQUEST FOR RECONSIDERATION.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute regards diagnostic laboratory services performed by an outpatient facility. DWC's *Hospital Facility Fee Guideline*, Rule §134.403(h) requires that if Medicare pays for hospital services using fee schedules or payment systems other than Medicare's Outpatient Prospective Payment System (OPPS), reimbursement is determined using the DWC fee guideline applicable to the code on the date provided. DWC *Professional Fee Guideline* Rule §134.203(e)(1), requires the reimbursement for laboratory services shall be 125% of the Medicare Clinical Fee Schedule rate for the technical component of the service.

Reimbursement for the disputed services is calculated as follows:

- Procedure code 36415 has status indicator Q4, for outpatient lab services. The Medicare Clinical Laboratory fee of $3.00 is multiplied by 125% for a total of $3.75.
- Procedure code 87389 has status indicator Q4, for outpatient lab services. The Medicare Clinical Laboratory fee of $29.73 is multiplied by 125% for a total of $37.16.

The total recommended reimbursement for the disputed services is $40.91. The insurance carrier paid $42.60. 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	March 22, 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.