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 Southlake

Respondent Name
Texas Council

MFDR Tracking Number
M4-19-4727-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
July 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The purpose of this letter is to inform you that payment for services provided to the above referenced patient does not comply with Chapters 134.403 and 134.404 of Texas Administrative Code."

Amount in Dispute: $52.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Your stands on the original audit results."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2018	Outpatient Hospital Services	$52.62	$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 hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines 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

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement in the amount of $52.62 for outpatient hospital services rendered on October 26, 2018. The insurance carrier reduced disputed services based on the workers' compensation jurisdictional fee schedule.

   Review of the submitted medical bill finds the following codes were submitted:

   - 36415, Routine venipuncture
   - 80053, Comprehensive metabolic panel
   - 85025, Complete cbc w/auto diff wbc
   - 85610, Prothrombin time
   - 85730, Thromboplastin time partial
   - 87077, Culture aerobic identify
   - 87086, Urine culture/colony count
   - 87186, Microbe susceptible mic
   - 81001, Urinalysis auto w/scope

   These codes have a status indicator of Q4 – In other circumstances, laboratory tests should have a status indicator of "A" and payment is made under the CLFS (Clinical Laboratory Fee Schedule).

   Based on the above the maximum allowable reimbursement is calculated below.

2. 28 Texas Administrative Code §134.203 (e) states in pertinent part,

   > 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 Laboratory Fee Schedule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html, finds none of the codes have a separate professional component. The MAR calculation is shown below.

Code	Submitted charge	Medicare Allowable	Maximum Allowable Reimbursement
36415	$29.50	3.00	3.75
80053	$515.50	13.04	16.30
85025	$169.75	9.59	11.99
85610	$114.50	4.85	6.06
85730	$171.50	7.42	9.28
87077	$215.75	9.97	12.46
87186	$311.00	10.67	13.34

81001	$196.25	3.92	4.90
87086	$136.00	9.96	12.45
		Total	$90.53

The total allowed amount is $90.53. The insurance carrier paid $92.22. 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

______________________	______________________	July 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, 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.