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
Physicians Surgical Hospital

Respondent Name
City of Amarillo

MFDR Tracking Number
M4-19-4929-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 19, 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: $85.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is our position that payment issued has been correct and no additional reimbursement is due."

Response Submitted by: CAS – Claims Administrative Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2019	Revenue Code 300-307	$85.17	$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 services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for laboratory charges.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 435 – Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. How is the maximum reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of clinical laboratory services provided in an outpatient setting on March 25, 2019. The insurance carrier reduced the charges based on the NCCI edits and denied code 87640 based on NCCI edits.

   28 TAC 134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

   The denial of code 87640 based on NCCI edits was not upheld upon reconsideration.

   28 TAC §134.403 (h) states

   > For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

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

   - 36415, Routine venipuncture
   - 80048, Metabolic Panel Total CA
   - 85025, Complete cbc w/auto diff wbc
   - 85610, Prothrombin time
   - 85730, Thromboplastin Time Part
   - 87640, Staph A DNA AMP probe
   - 87641, MR-Staph DNA Amp probe
   - 85730, Thromboplastin time partial
   - 81001, Urinalysis auto w/scope

   These codes have a status indicator of Q4 – defined as "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 2019 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	$31.00	$3.00	$3.75
80048	$149.50	$9.40	$11.75
85025	$78.20	$8.63	$10.79
85610	$29.90	$4.37	$5.46
85730	$64.40	$6.67	$8.34
87640	$181.70	$38.99	$48.74
84641	$185.15	$38.99	$48.74
81001	$42.55	$3.52	$4.40
		Total	$141.97

3. The total allowed amount is $141.97. The insurance carrier paid $141.97. 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

Signature	Medical Fee Dispute Resolution Officer	August 9, 2019 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.