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 DALLAS

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-5268-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 23, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"Underpaid/Denied Lab Charge"

RESPONDENT'S POSITION SUMMARY

"Texas Mutual processed the bill in accordance with Medicare Rates for Clinical Laboratory Fee schedule CY_Q3 multiplied by 1.25%, the bill was processed correctly, no additional payment due."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 30, 2019	Outpatient Clinical Laboratory Services	$38.82	$0.00

AUTHORITY

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 (DWC).

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.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 356 – THIS OUTPATIENT ALLOWANCE WAS BASED ON THE MEDICARE'S METHODOLOGY (PART B) PLUS THE TEXAS MARKUP.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Findings

This dispute regards outpatient clinical lab services not paid under Medicare's Outpatient Prospective Payment System but instead using Medicare's Clinical Laboratory Fee Schedule. DWC *Hospital Fee Guideline* 28 Texas Administrative Code §134.403(h) requires use of the DWC fee guideline applicable to the code on the service date if Medicare pays using other fee schedules. The applicable rule is DWC's *Professional Services Guideline* 28 TAC §134.203(e)(1), which requires the maximum allowable reimbursement (MAR) be determined at 125% of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service.

Reimbursement is calculated as follows:

- Procedure code 87070: Medicare's Clinical Lab fee is $9.57. 125% of this amount is $11.96
- Procedure code 87075: Medicare's Clinical Lab fee is $10.52. 125% of this amount is $13.15
- Procedure code 87077: Medicare's Clinical Lab fee is $8.97, a t 3 units is $26.91. 125% of this amount is $33.64
- Procedure code 87205: Medicare's Clinical Lab fee is $4.75. 125% of this amount is $5.94

The total recommended reimbursement for the disputed services is $64.69. The insurance carrier paid $64.68. Additional payment is not recommended.

Conclusion

The requestor has not established that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

_______________	Grayson Richardson	September 20, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.