TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
St Joseph Medical Center

Respondent Name
Argonaut Midwest Insurance Co

MFDR Tracking Number
M4-22-1054-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
February 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 20, 2021	Lab Fees	$62.22	$0.00
	Total	$62.22	$0.00

Requestor's Position

Per Texas Fee Schedule, this bill has been underpaid.

Amount in Dispute: $62.22

Respondent's Position

The Austin carrier representative for Argonaut Midwest Insurance Co is Downs Stanford. The representative was notified of this medical fee dispute on February 8, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 out the fee guidelines for clinical laboratory fees.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's reduction based on fee schedule supported?

Findings

1. The requestor is seeking reimbursement of outpatient laboratory services. DWC Rule 134.203 (e) states in pertinent part, the MAR for pathology and laboratory services shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule. The maximum allowable reimbursement based on the applicable fee guideline is:

    - 36415 allowed amount $3.00 x 125% = $3.75
    - 80053 allowed amount $10.56 x 125% = $13.20
    - 85025 allowed amount $7.77 x 125% = $9.71
    - 87086 allowed amount $8.07 x 125% = $10.09
    - 87635 no allowable found for this code at www.cms.gov
    - 81009 allowed amount $2.25 x 125% = $2.81

The total allowed amount is $39.56. The insurance carrier paid $103.70. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 13, 2022 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.