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
Service Lloyds Insurance Co

MFDR Tracking Number
M4-22-1094-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
February 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 22, 2021	Laboratory Services	$117.04	$0.00
	Total	$117.04	$0.00

Requestor's Position

Per Texas Fee Schedule, this bill remains underpaid after appeal.

Amount in Dispute: $117.04

Respondent's Position

The previous review is being maintained (payment of $24.04) and no additional allowance is recommended as the line denied was beyond the extent of injury and paid within the DWC guidelines.

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 sets out the fee guidelines of professional medical claims.

Denial Reasons

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

- 219 – Based on extent of injury
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's denial based on extent of injury supported?

2. What rule is applicable to reimbursement?

3. Is the requestor due additional reimbursement?

Findings

1. The insurance carrier denied Code 87635-CR as 219 – Based on extent of injury.

   DWC Rule 133.307 (d)(2)(H) states that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

   The insurance carrier failed to provide the PLN-11 to support its denial, DWC records finds that the insurance carrier failed to file the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) to DWC prior to or concurrent with the date that it took final action on this medical bill. For those reasons, the insurance carrier's extent denial is unsupported. The service in dispute will be reviewed per applicable fee guidelines.

2. The requestor is seeking reimbursement of clinical laboratory services rendered in an outpatient hospital setting. The applicable fee guideline is found at 28 TAC §134.203 which states in pertinent part, the MAR for pathology and laboratory services shall be determined as 125 of the fee listed for the code in the Medicare Clinical Fee Schedule. Review of the applicable clinical laboratory fee schedule found at www.cms.gov the allowable is calculated as follows:

Submitted Code	Fee Schedule Amount	Maximum Allowable Reimbursement
36415	$3.00	$3.75
80048	$8.46	$10.58

85025	$7.77	$9.71
87365	$0.00	$0.00
	Total	$24.04

Review of clinical laboratory fee schedule for 2021 found no payment amount for Code 87365.

3. The total allowable for the disputed service is $24.04. This insurance carrier paid $24.04. 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	March 7, 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.