



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

Texas Health Fort Worth

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-18-4149-01

Carrier's Austin Representative

Box Number 4

MFDR Date Received

July 2, 2018

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: \$59.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Additional payment owe for lab services of the whole procedure paid under the clinical lab fee schedule."

Response Submitted by: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2 – 14, 2018	Outpatient Hospital Services	\$59.61	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient services.
- 28 Texas Administrative Code §134.203 sets out the guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated

Issues

1. What rule is applicable to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for outpatient services performed from February 2 – 14, 2018. The carrier reduced the allowed amount as P12 – “Workers’ compensation jurisdictional fee schedule adjustment.”

The applicable Division Rule is found in 28 Texas Administrative Code 134.403. The applicable sections are listed below:

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

(h) 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.

The OPPS reimbursement formula factors are found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>. The specific factor is the Status Indicators. The status indicator for each of the HCPCs code listed on the DWC060 have a “Q4” status indicator which is defined as, “(2) In other circumstances, laboratory tests should have an **SI=A**, and payment is made under the **CLFS**.”

Based on the requirements of 28 Texas Administrative Code 134.403 (h) the applicable Division fee Guideline is found in 28 Texas Administrative Code §134.203 (e).

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

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 Medicare Clinical Diagnostic Laboratory Fee schedule found none of the services in dispute has a professional component. Therefore the MAR is calculated based on 28 Texas Administrative Code §134.203 (e)(1). The calculation is as follows:

- Procedure code 87070, billed February 2, 2018. The Medicare Clinical Fee Schedule is \$10.64 x 125% = \$13.30
- Procedure code 87070, billed February 14, 2018. The Medicare Clinical Fee Schedule is \$10.64 x 125% = \$13.30

- Procedure code 87077, billed February 2, 2018. The Medicare Clinical Fee Schedule is \$9.97 x 125% = \$12.46.
- Procedure code 87077, billed February 14, 2018. The Medicare Clinical Fee Schedule is \$9.97 x 125% = \$12.46.
- Procedure code 87147, billed February 14, 2018. The Medicare Clinical Fee Schedule is \$6.39 x 125% = \$7.99
- Procedure code 87186 billed February 2, 2018. The Medicare Clinical Fee Schedule is \$10.67 x 125% = \$13.34
- Procedure code 87186 billed February 14, 2018. The Medicare Clinical Fee Schedule is \$10.67 x 125% = \$13.34
- Procedure code 87205 billed February 2, 2018. The Medicare Clinical Fee Schedule is \$5.27 x 125% = \$6.59
- Procedure code 87205 billed February 14, 2018. The Medicare Clinical Fee Schedule is \$5.27 x 125% = \$6.59.

The total allowed amount is \$99.37. The carrier paid \$143.47. 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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 13, 2018 Date
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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.