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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SurgInsite Southeast Texas

Respondent Name
Protective Insurance Co

MFDR Tracking Number
M4-13-0334-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are 2 copies of completed DWC FORM-060 for the patient listed below. These completed forms are also accompanied by all supporting documentation that was stated as required and/or applicable."

Amount in Dispute: $24,785.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement was submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2011 November 7, 2011 November 14, 2011 February 9, 2012 February 16, 2012 February 23, 2012	64640	$24,785.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §133.10 sets out required billing forms/formats.
3. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by health care providers.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. Did the respondent support reduction of disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2912. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. 28 Texas Administrative Code §133.20(c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Review of the submitted documentation finds;
    a. Claim submitted on UB - 04 as type of bill 831
    b. Claim submitted on UB – 04 as type of bill 131

    The NPI number submitted for the health care provider is 1922301480. This number is associated with a clinic/center multi-specialty. Not an out-patient hospital as indicated by type of bill 131nor an ambulatory surgical center as indicated by type of bill 831.

    Requirements of Rule 133.20 not met. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has 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 Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 7, 2014 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 Texas Administrative Code §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 MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.