



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

LAFAYETTE SURGICAL CENTER

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-15-1194-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Lafayette General Surgical Center to audit their Workers Compensation claim. We have found in this audit they have not paid what we determine is the correct allowable per the new fee schedule that took effect in March of 2008 for this outpatient surgery ...

We are forced to file this as a Medical Dispute to get a resolution to this claim, as the carrier has yet to respond or evaluate this appeal. We try to get resolutions on claims without having to file disputes, but there are times when this is the only recourse we have."

Amount in Dispute: \$771.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that MDR Tracking Number M4-15-1194-01 [injured employee] has not been resolved. The Carrier, New Hampshire Insurance Company is maintaining their position that the additional \$771.89 for the 4/19/2013 date of service is not owed to the requestor, Lafayette Surgical Center."

Response Submitted by: AIG Services Dallas Worker's Compensation Service Center

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 19, 2013	CPT Code 49652	\$771.89	\$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. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B – Recommendation of payment has been based on this procedure code, 49652, which best describes services rendered
 - C – The recommended allowance on this line is based on TX fee schedule reimbursement guidelines which allows greater than the providers billed charges
 - 4 – (94) Processed in Excess of charges

- 4 – This is a bundled or non-covered procedure based on Medicare guideline; no separate
- 6 – No reduction available
- 1 – (129) Prior processing information appears incorrect
- 1 – The Federal Tax ID Number entered on the billing form is invalid. Please return this form with the required information
- 6 – Recommendation of payment has been based on this procedure code 49652, which best describes services rendered

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is April 19, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 16, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/13/15 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 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.