



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FOREST PARK MEDICAL CENTER

Respondent Name

AMTRUST INS CO OF KANSAS INC

MFDR Tracking Number

M4-16-1045-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in receipt of the benefit payment for the attached claims. It is our understanding that benefits were significantly reduced due to Worker's Compensation Fee Schedule Adjustment. According to Title 28. Insurance Part 2. Texas Department of Insurance. Division of Workers' Compensation Chapter 134. Benefits-Guidelines for Medical Services, Charges, and Payments, Subchapter E. Health Facility Fee 28 TAC 134.403 and 134.404, we do not believe the reductions are justified. The payment rendered does not appear to be paid in accordance with the Texas Department of Insurance Medical Fee Guidelines. Justification of your reduction does not appear to have been provided to support your position that the underpayment is in accordance with the Fee Schedule guidelines."

Amount in Dispute: \$16,303.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 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 December 29, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 07, 2014, Outpatient Hospital Services, \$16,303.33, \$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 350 – Bill has been identified as a request for reconsideration or appeal
 - 351 – NO additional reimbursement allowed after review of appeal/reconsideration
 - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
 - 619 – The procedure/supply was not sufficiently identified and/or quantified
 - 668 – The allowance for this line item is base on an outlier reimbursement
 - P12 – Workers' Compensation jurisdictional fee schedule adjustment
 - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

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 November 07, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on December 16, 2015. 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

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

2/24/16
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 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 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.