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
BAYLOR SURGICARE AT OAKMONT

Respondent Name
TWIN CITY FIRE INSURANCE CO

MFDR Tracking Number
M4-17-0294-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
OCTOBER 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on this fee schedule, the correct amount due for procedure 25608 should be $6826.47 (235% of the $2904.88 Medicare allowable), and the correct amount due for procedure 25676 should be $1275.24 (235% of the $542.86 Medicare allowable, with 50% multiple procedure discount applied). Please reprocess and pay the additional $641.94 due for these services."

Amount in Dispute: $641.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per review of medical fee dispute no additional monies are owed."

Response Submitted By: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2015	Ambulatory Surgical Care Services CPT Code 25608-SG-RT	$641.94	$0.00
	Ambulatory Surgical Care Services CPT Code 25676-SG-RT		

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 a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - 851-The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
    - 983-Charge for this procedure exceeds Medicare ASC schedule allowance.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
    - W3-Addito al payment made on appeal/reconsideration.
    - 193-Original payment decision is being maintained. This claim was processed properly the first time.
    - 1014-The attached billing has been re-evaluated at the request of the provider based on this re-evaluation. We find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issue

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

Findings

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 service in dispute is February 26, 2015. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 4, 2016. 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

		12/8/2016
Signature	Medical Fee Dispute Resolution Officer	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.