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
MVP SPECIALIST SURGERY CENTER

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-3031-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $28,377.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider failed to file the DWC-60 within one year of the January 10, 2018 date…The provider's DWC-60 has requested additional reimbursement under CPT codes 63047, 63048 and 22850. However, CPT codes covering procedures 63048 and 22850 are excluded from being performed in an ambulatory surgical center (ASC) based upon CMS procedures. In order for procedures that are excluded from being performed by ASC, the provider must show that it falls within that part of Division rule 134.402 that would allow reimbursement….If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier and the health care provider and the ASC may agree on a voluntary basis to reach an agreement that occurs before or during preauthorization…There was no agreement…the carrier previously reimbursed the provider the amount of $2,325.75 under CPT codes 63047…$448.80 under CPT code 63048; and…$761.56 under CPT code 22850. However, the carrier also reimbursed the provider the amount of $4,985.00 under CPT code A4649. The total reimbursement was $8,521.11…the provider is not entitled to any additional reimbursement as noted in the carrier's EOBs."

Response Submitted By: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 23, 2017	CPT Code 63047 Ambulatory Surgical Care Services	$831.89	$0.00

October 23, 2017	CPT Code 63048 Ambulatory Surgical Care Services	$10,137.20	$0.00
	CPT Code 22850 Ambulatory Surgical Care Services	$17,408.44	$0.00
TOTAL		$28,377.53	$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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 329-allowance for this service represents 50% because of multiple or bilateral rules.
   - 18-Exact duplicate claim/service
   - 224-Duplicate charge.
   - W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

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 October 23, 2017. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 4, 2019. 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 for these services.

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 for those dates 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

		3/05/2019
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.