



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

FORT WORTH INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number

M4-19-3893-01

Carrier's Austin Representative

Box Number 16

MFDR Date Received

April 23, 2019

Response Submitted By

IMO - Injury Management Organization, Inc.

REQUESTOR'S POSITION SUMMARY

"This should have been processed under the case calculator that was effective for this date of service."

RESPONDENT'S POSITION SUMMARY

"The bill was processed and paid per the Fee Schedule."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 8, 2018	Ambulatory Surgery	\$5,906.43	\$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 4123 – ALLOWANCE IS BASED ON TEXAS ASC DEVICE INTENSIVE PROCEDURE CALCULATION AND GUIDELINES.
 - 983 – CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC SCHEDULE ALLOWANCE.
 - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
 - W3 – [no definition or explanation for this code was found with the submitted materials.]
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
 - 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.

Issues

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

Findings

28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

The disputed date of service is March 8, 2018.

The request was received in the division’s MFDR Section on April 23, 2019.

This date is later than one year after the disputed date of service.

Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B). Consequently, the MFDR request was not timely filed with the division. The requestor has thus waived the right to medical fee dispute resolution for these services.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

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

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	May 7, 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 Rule §133.307. The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.