



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

BAYLOR SURGICARE AT OAKMONT

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-19-4075-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

MAY 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Under the Texas Workers Comp Fee Schedule in effect 09-01-08, when separate payment for implants is not expected, claims are to be paid at 235% of the Medicare allowable for the geographical area in which the service is performed...The correct amount due for procedure code 25608 is \$8,778.64...64417 is \$403.00."

Requestor's Supplemental Position Summary: "I just got off the phone with Greg A. He asked me to send an email stating that we did receive the additional payment of \$247.10 from ESIS, but they have not paid correctly. They have a balance still due of \$3272.69 and we are not happy with the small payment."

Amount in Dispute: \$3,519.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of MDR, the bill was sent for reconsideration. Payment in the amount of \$247.10 was issued on 6/7/19."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 1, 2018	Ambulatory Surgical Care Services CPT Codes 25608 and 64417	\$3,519.79	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced / denied by the respondent with the following reason code:
 - B12-Services not documented in patient's medical records.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18-Exact duplicate claim/service.
- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

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 March 1, 2018. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 8, 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

Signature

Medical Fee Dispute Resolution Officer

06/20/2019

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.