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 and Address

ALEGIS REVENUE GROUP LLC
1201 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-0477-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

OCTOBER 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached is our request for an MFDR please review all provided documentation and process our request."

Amount in Dispute: $1,672.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I am responding on behalf of New Hampshire Insurance Company. After reviewing the documentation from the requestor, I have asked the medical review division for the carrier to re-examine this bill and process it for payment. The denial reason is the bill was not submitted timely; however it appears to me that it was."

Response Submitted by: AIG, 4100 Alpha Rd., Ste. 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2012 through June 1, 2012	Outpatient Hospital Services	$1,672.18	$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 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A – E - Recommendation of payment has been based on this procedure… which is best describes the services rendered.
   - 1 – (45) = Charge exceeds fee schedule/maximum allowable or contracted/legislated fee.
   - 1 – Documentation shows hospital stay exceeds 23 hours.

- 2 – 9 – Recommendation of payment has been based on this procedure code… which best describes services rendered.
- Based on state guidelines, this bill has exceeded the timely filing rule.

Issue

1. 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 with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution 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 dates of the service in dispute are May 28, 2012 through June 1, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on October 7, 2013. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed service does not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR 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. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

		February 28, 2014
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.