



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

UNIVERSAL DME LLC

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-15-0361-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "On 07/19/2013 we submitted our claims for payment to AIG-Chartis-25975 in the amount of \$1584.11 via fax 866-739-6983. The claim was then processed and denied on 08/09/2013. We submitted an appeal on 09/10/2013 where we then received payment for E0218 in the amount of \$58.07. We then submitted two additional appeals on 05/27/2014 and again on 07/24/14 where we continued to get denied payment on the balance. E0673 and E0675 are denying due to the charges being included in the facility fee. The appeals that were submitted on 05/27/2014 and 07/24/2014 explained that we are a Durable Medical Equipment Supplier that delivered the supplies to the patient at Dallas Medical Center. Our services are separate from the facility charges."

**Amount in Dispute:** \$1,374.40

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "AIG has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that in accordance with Texas Labor Code, Rule 133.307(c)(1)(A), the request for medical fee dispute resolution was not filed within one year from the date of service in dispute and this request does not involve issues identified in subparagraph (B). Therefore, in accordance with the Statute, the provider has waived the right to medical fee dispute resolution."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 09, 2013	CPT Code E0675, E0673 and E0218	\$1,374.40	\$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 codes:

- 1 (97) – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 1 – Charges included in the facility fee
- 2 – (45) Charge exceeds fee schedule/maximum allowable or contract/legislated fee arrangement
- 2 – This procedure is included in another procedure performed on this date
- 3 (217) – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement
- 3 – No reduction available
- 4 – The amount paid reflects the usual and customary charge
- 5 – The charge for this procedure exceeds the customary charges by other providers for this service

**Issue**

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

**Findings**

1. 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 the services in dispute is July 09, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on September 22, 2014. 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**

Signature	Medical Fee Dispute Resolution Officer	2/27/15 Date
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**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.**