



**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**

MEDME SERVICES CORPORATION

**Respondent Name**

EL PASO ISD

**MFDR Tracking Number**

M4-15-0655-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

OCTOBER 17, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The reason why the disputed fees should be paid is because the rental of the TENS Unit was approved for a one month trial period on 10-14-13. Payment was received for the rental of the TENS. However the payment amount was paid well below the rental allowable as the **TENS and NMES units are both stimulation devices that are both rented and purchased equipment.** The allowable does not reflect the RENTAL amount for TENS (E0730) only purchase. The allowable does not reflect the PURCHASE amount for NMES (E0745) only rental."

**Amount in Dispute:** \$85.60

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Bill Audit Solutions has reviewed the billed charges that were originally processed by the previous audit company and noted that the Medical Dispute resolution request was submitted on 10/17/2014, which is beyond one year from the DOS for the medical fee dispute in question. Per Rule 133.307(1)(A) the health care provider has one year from the DOS to submit a medical dispute resolution."

**Response Submitted by:** Bill Audit Solutions

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October14, 2013	E0730-RR	\$85.60	\$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 resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 219 – Based on extent of injury
  - 197D – Precertification /authorization/notification absent. \*Health care treatments/services that are not recommended, not listed, or under study by the ODG, or exceeded the ODG in frequency or duration require pre-authoriazation.\*

- 96A – Non-covered charge(s). \*Tax, Freight, Shipping and Handling charges are not a reimbursable benefit.\*
- W3 – Additional payment made on appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**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 10/14/2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on 10/17/2014. 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**

	<b>Debra Hausenfluck</b>	<b>November , 2014</b>
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.**