



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

Duramed

Respondent Name

Arch Indemnity Insurance Co

MFDR Tracking Number

M4-19-5059-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 31, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient has a contested case hearing ... carrier is court ordered to pay in full."

Amount in Dispute: \$529.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement submitted.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 28, 2018, Durable medical equipment, \$529.25, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- July 12, 2018 - 219 / Based on extent of injury
- October 4, 2018 - 219 / based on extent of injury
- March 21, 2019 - 18 / Duplicate claim, 24G12 / Precertification absent
- June 19, 2019 - 29 / Time limit for filing has expired
- June 19, 2019 - 193 / Original payment decision is being maintained

Issue

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

Findings

The Austin carrier representative for Arch Indemnity Insurance Co is Flahive, Ogden & Latson who acknowledged receipt of the copy of this medical fee dispute on August 7, 2019.

28 TAC §133.307 states in relevant parts the response will be deemed timely if received by DWC via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If DWC does not receive the response information within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

Review of the documentation finds that no response has been received to date. DWC will base its decision on the information available.

28 TAC §133.307(c)(1)(B) requires a request for medical fee dispute resolution to be filed no later than one year after the date of service in dispute unless a related extent of injury exists then the disputed must be filed within 60 days after the requestor receives the final decision.

The date of the service in dispute is June 28, 2018. A contested case hearing was completed February 26, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 31, 2019.

This date is later than 60 days of the contested case hearing.

DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

DWC 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.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 16, 2019

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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.