**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**
SETON MEDICAL CENTER

**Respondent Name**
NEW HAMPSHIRE INSURANCE COMPAN

**MFDR Tracking Number**
M4-12-3087-01

**Carrier's Austin Representative Box**
Box Number: 19

**MFDR Date Received**
June 11, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The attached claim was processed and paid by your company. However, the reimbursement issued was significantly below the current Division of Workers' Compensation prescribed fee schedule. The MAR (Maximum Allowable Reimbursement) should be calculated at 143 percent of Medicare's Inpatient Prospective Payment System (IPPS) rate in accordance with 28 TEX. ADMIN. CODE §134.404(f)."

**Amount in Dispute**: $29,838.55

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "I am responding on behalf of Chartis, the claims handling entitle for New Hampshire Insurance Company. Seton Medical Center billed $30,274.00 service. [injured worker] had a partial medical menisectomy of the left knee. The carrier returned the bill requesting more information in order to properly audit the bill. (See Exhibit A, page 1 & A, page 2) When reconsideration was requested reimbursement was denied as the request for reconsideration was not submitted within the 11 month time frame required b DWC Rule 133.250. (see Exhibit B&C)"

**Response Submitted by:** Chartis

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 17, 2010 | J0690, J1100, J1170, J1885, J2250, J3010, L1830, C713, 27428LT, 2733359LT, 97110GP, 97530GP, 97001GP, J2405, 93005 and G0378 | $29,838.55 | $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.

**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 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 date of the services in dispute is September 17, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 11, 2012. 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, 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**

| Signature | Medical Fee Dispute Resolution Officer | 4/25/2014<br>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**.