



# 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**

LISA PERSYN MD

**Respondent Name**

LM INSURANCE CORP

**MFDR Tracking Number**

M4-15-2685-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

April 21, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a request for reconsideration to Liberty Mutual on 8-15-14, this request was in response to a \$819.38 no payment of the \$819.38 for the EMG performed on 4-12-14. Unfortunately our request was denied and we are seeking the balance owed to us.

I have not EOB's regarding this patient. I called bill review and they stated bill was never received which is incorrect. Confirmation of 1<sup>st</sup> and 2<sup>nd</sup> submission is attached where it was sent to the carrier."

**Amount in Dispute:** \$819.38

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Attached acknowledges receipt of a medical fee dispute on a HCN claim for [injured employee]."

**Response Submitted by:** Liberty Mutual Insurance

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12, 2014	CPT Code 99204, 95886, 95911 and A4556	\$819.38	\$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 §134.1 sets out the procedures for medical reimbursement policies.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - No explanation of benefits provided

**Issues**

1. Is the requestor subject to reimbursement in accordance with 28 Texas Administrative Code §134.1?
2. Did the requestor waive the right to medical fee dispute resolution?

**Findings**

1. 28 Texas Administrative code §134.1(b) states:

Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.

(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

Review of the submitted documentation provided by the requestor finds disputed service are for a Request for Commissioner Order/ Request for Designated Doctor Examination to address extent of injury and disability.

2. 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 April 12, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 21, 2015. 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**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***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 disputed services.

**Authorized Signature**

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Signature	Medical Fee Dispute Resolution Officer	5/22/15 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 MFDR 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.**