



# 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**

Atlas Neurophysiological Assessment

**Respondent Name**

Liberty Mutual Fire Insurance

**MFDR Tracking Number**

M4-20-1722-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

March 12, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We are requesting that Liberty Mutual pay procedure codes 95938 and 95939 accordingly with any interest that would be owed due to the error of non-payment."

**Amount in Dispute:** \$282.36

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "CPT codes 95938 26 and 95939-26 were adjusted for payment based on Texas Medicare LCD L34975 as payable codes for the diagnosis codes billed..."

**Response Submitted by:** Liberty Mutual

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2019	95938, 95939	\$282.36	\$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**

- 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:
  - 531 – Please re-submit with the appropriate HCPCS/CPT Code

**Issue**

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

**Findings**

28 TAC §133.307(c)(1) states a request for medical fee dispute resolution that does not involve issues of compensability, extent of injury, liability, medical necessity or a refund shall be filed no later than one year after the date(s) of service in dispute.

The date of the service in dispute is January 22, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 12, 2020.

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 above.

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**

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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, DWC has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

		March 31, 2020
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 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.**