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
ADVANCE REHAB & CONSULTING LP

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-21-0267-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Advance Rehabilitation & Consulting L.P., is requesting a review and payment for the date of service 2/15/2018-3/14/2018 which were denied for lack of modifier. The original claim was submitted to Liberty as the original payor. We have reached out to Farmers via Corvel more than once for resolution of this claim without success. I am attaching the claim w/ notes to this letter as well as claim transaction history for proof of timely filing."

Amount in Dispute: $3,894.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This bills for DOS 2/15/2018 thru March 14, 2018 will not be reviewed as this dispute has been submitted past the timely filing deadline per Rule 133.307; A request for MFDR that does not involve identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. The DOS is later than 1 year after the Dates of service in dispute."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2018	Code 97545	$3,894.00	$0.00
February 19, 2018	Code 97545 and 97546		
February 21, 2018	Code 97545 and 97546		
February 23, 2018	Code 97545 and 97546		
February 26, 2018	Code 97545, 97546		

February 28, 2018	Code 97545 and 97546		
March 02, 2018	Code 97545 and 97546		
March 05, 2018	Code 97565 and 97546		
March 07, 2018	Code 97545 and 97546		
March 14, 2018	Code 97545 and 97546		

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:
    - E483 – Modifier is required for this procedure. Resubmit service with appropriate modifier
    - ZC72 – In the event this payment needs to be returned to the payer, Please return the check to PO Box 8011, Wausau
    - 10 – The billed service requires the use of a modifier code
    - W3 – Additional payment made on appeal/reconsideration/additional payment made on appeal/reconsideration

Issues

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 February 15, 2018; February 19, 2018; February 21, 2018; February 23, 2018; February 26, 2018; February 28, 2018; March 2, 2018; March 5, 2018; March 7, 2018 and March 14, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 13, 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 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

[redacted]	[redacted]	October 29, 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 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.