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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RMJ EVALUATIONS

Respondent Name
Liberty Insurance Corporation

MFDR Tracking Number
M4-19-5299-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is still RMJ Evaluations position that we have not received payment for this examination."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "From our review, it appears the provider cashed the check twice. First 5/14/19 and then again on 5/22/19. An email was sent to our Treasury Team who did confirm since the check presented 8 days apart the bank would have auto returned the second presentment; they would not have received the funds twice."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$650.00

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 (DWC). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is RMJ Evaluations entitled to reimbursement for the disputed service?

Findings

The insurance carrier asserted that the services in question were paid in full per explanation of benefits dated May 6, 2019.

Based on the weight of the documentation submitted, including sworn affidavits by the health care provider, the DWC finds that RMJ Evaluations is entitled to reimbursement of $650.00.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 19, 2019
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 Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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. **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.