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*

**Requester Name**
MEDICAL EVALUATORS OF TEXAS

**Respondent Name**
LIBERTY MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-20-2555-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
June 24, 2020

## *REQUESTER'S POSITION SUMMARY*

"The complete/clean bill was submitted to the carrier for reimbursement on 12/12/2019 by MET Healthcare Solutions (MET), Dr. Smith's billing provider … On 01/16/2020, an MET representative contacted the adjuster via email to confirm bill receipt. The adjuster did not reply to this email. On 01/30/2020, MET again sent an email to the adjuster requesting payment information. The adjuster, again, did not reply. On 03/04/2020, MET placed a call to the adjuster for payment status, the adjuster did not answer the phone and a voicemail was left. The adjuster did not return this call."

**Amount in Dispute:** $950.00

## *RESPONDENT'S POSITION SUMMARY*

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 3, 2019 | Designated Doctor Examination (99456-W5-WP) | $950.00 | $950.00 |

## *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).

**Background**

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

4. The submitted documentation does not include explanations of benefits.

**Issues**

1. Did Liberty Mutual Insurance Company respond to the medical fee dispute?
2. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Medical Evaluators of Texas entitled to reimbursement for the examination in question?

**Findings**

1. The Austin carrier representative for Liberty Mutual Insurance Company is JT Parker and Associates. The representative was notified of this medical fee dispute on June 30, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Medical Evaluators of Texas is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating. Medical Evaluators of Texas argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[2]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier raised no defenses for non-payment of the examination in question, Medical Evaluators of Texas are entitled to reimbursement.

   The submitted documentation supports that Carlton Smith, M.D. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   Review of the submitted documentation finds that Dr. Smith performed impairment rating evaluations of the upper extremities, thoracic spine, and lower extremities. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[5] The total MAR for the determination of impairment rating is $600.00.

   The total allowable reimbursement for the examination in question is $950.00. This amount is recommended.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requester and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $950.00.

---

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-b-)

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $950.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

| | | |
|---|---|---|
| | | September 23, 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 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**.