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
PULIDO, CHRISTOPHER

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-0234-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 13, 2020

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED … OUR CONFIRMATIONS ARE ATTACHED FOR THE FAX NUMBER LISTED IN THE ATTACHED DWC 32 FORM."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

"The billing was sent directly to our branch office and not to the billing center. We have requested a rush review and will forward a copy of the payment information and EOB as soon as it has been finalized by the bill review company. Supplemental response will be provided once the bill review company has finalized their review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2019	Designated Doctor Examination (99456-W5-WP)	$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).

Background

1. 28 Texas Administrative Code §133.210 sets out the procedures related to medical documentation.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
5. The submitted documentation did not include explanations of benefits.

Issues

1. Did Liberty Mutual Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Christopher Pulido, D.C. entitled to reimbursement for the examination in question?

Findings

1. Dr. Pulido is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

   Dr. Pulido argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question. Gallagher Bassett, on behalf of Liberty Mutual Insurance Company, argued that "The billing was sent directly to our branch office and not to the billing center."

   The insurance carrier has the obligation to provide its agents with the documents necessary to resolve a medical bill. The DWC considers any medical billing information or documentation possessed by the insurance carrier or its agents to be simultaneously possessed by the other.[1]

   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.

2. Gallagher Bassett stated that "Supplemental response will be provided once the bill review company has finalized their review." As of today, no supplemental response has been received by the DWC. Because the insurance provided no defense for non-payment of the examination in question, Dr. Pulido is entitled to reimbursement.

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

   The submitted documentation supports that Dr. Pulido provided an impairment rating for a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[4]

   The total allowable reimbursement for the examination in question is $650.00. This amount is recommended.

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.

---

[1] 28 TAC §133.210 (e)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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

Signature	Medical Fee Dispute Resolution Officer	February 10, 2021 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.