TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
James Bales, M.D.

Respondent Name
Liberty Insurance Corp.

MFDR Tracking Number
M4-25-0893-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
December 19, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 1, 2024	Designated Doctor Examination 99456-W5	$1,218.00	$0.00
	Designated Doctor Examination 99456-25	$300.00	$0.00
	Total	$1,518.00	$0.00

Requestor's Position

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

Amount in Dispute: $1,518.00

Respondent's Position

"Upon further review, we have found that an overpayment was issued on 12/13/2024 in the amount of $129.00."

Response Submitted by: Liberty Mutual Insurance

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier paid the payment for the disputed services with the following claim adjustment codes:

- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the comp0ensable injury was also performed.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 4097 – Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge.
- 56 – Significant, separately identifiable E/M service rendered.

Issues

1. Is James Bales, M.D., entitled to additional reimbursement?

Findings

1. Dr. Bales is seeking reimbursement of $1,518.00 for an examination to determine maximum medical improvement and impairment rating.

   Per explanation of benefits dated December 12, 2024, the insurance carrier paid $1,647.00, stating, in part, "Paid per fee schedule; charge adjusted because statute dictates allowance is greater than provider's charge."

   DWC finds that Dr. Bales is not entitled to additional reimbursement for the services in question.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 21, 2025 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.