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
Gilbert Mayorga, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-19-3285-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
February 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the patient was seen for a designated doctor evaluation on 03/05/2018. However, we have not reimbursed for line item, 99456-NM in the amount of $350.00."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One or more Diagnosis and-or Procedure Code(s) is incomplete on the medical bill."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2018	Designated Doctor Examination	$350.00	$350.00

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.

Background

1. 28 Texas Administrative Code §133.10 sets out the procedures for completing 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 schedule for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 146 – Diagnosis was invalid for the date(s) of service reported.
   - 18 – Exact duplicate claim/service

Issues

1. Is the insurance carrier's denial of payment based on diagnosis supported?
2. Is Gilbert Mayorga, M.D. entitled to reimbursement for the examination in question?

Findings

1. Dr. Mayorga is seeking reimbursement for a designated doctor examination as ordered by the division. In its explanation of benefits dated March 27, 2018, the insurance carrier denied the designated doctor examination based on diagnosis.

   Review of information available to the division finds that Dr. Mayorga performed and billed an examination to determine maximum medical improvement in accordance with an order from the Commissioner of the Division of Workers' Compensation. The division finds that the insurance carrier's denial of payment for this reason is not supported.

2. If the designated doctor determines that maximum medical improvement has not been reached, the designated doctor is required to bill the examination with CPT code 99456 and modifier "NM."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Mayorga performed an evaluation of maximum medical improvement as ordered by the division. Therefore, the maximum allowable reimbursement for this examination is $350.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	March 22, 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 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. **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.

[1] 28 Texas Administrative Codes §§134.250(2)(A)
[2] 28 Texas Administrative Code §134.250(3)(C)