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
American Zurich Insurance Company

MFDR Tracking Number
M4-19-3398-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier denied it based off of billing error, which was corrected and was submitted before the 95th day, and have not received response from the carrier to date."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00. At this time, we are unable to process this bill due to the reporting of invalid ICD-10 code X00.03XD."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	Designated Doctor Examination	$800.00	$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.

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:
   - 418 – Resubmit bill with appropriate ICD-10 diagnosis codes: X00.03D is invalid.
   - 146 – Diagnosis was invalid for the date(s) of service reported.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is Dr. Mayorga entitled to additional reimbursement?

Findings

1. Dr. Mayorga is seeking reimbursement for a designated doctor examination as ordered by the division. In its explanation of benefits dated March 14, 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 submitted a complete medical bill for 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. The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[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 DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   Review of the submitted documentation finds that Dr. Mayorga performed impairment rating evaluations of a puncture wound and facial nerve injury. The MAR for the evaluation of non-musculoskeletal body areas is $150.00.[3] The impairment rating is assigned using the fourth edition of the *AMA Guides to the Evaluation of Permanent Impairment*. Dr. Mayorga provided an impairment rating of the puncture wound based on Chapter 13 (Skin), Table 2 and the facial nerve injury based on Chapter 4 (Neurologic), Table 10 of the *AMA Guides*. The total MAR for the determination of impairment rating of the two body areas is $300.00.

   The total allowable reimbursement for the disputed services is $650.00. 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 $650.00.

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 $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	April 18, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(D)(v)

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.