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
PA Manufacturers Association Insurance Company

MFDR Tracking Number
M4-19-3593-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… we were not paid for line item 99456-SP which was required in order to prepare the report. Therefore, we request that we be reimbursed as allowed by the Texas Fee Guideline for this line item the amount of $50.00."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent issued payment of $50.00 to provider on check number C0009850138 issued on April 4, 2019."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 2, 2018	Designated Doctor – Specialist Report	$50.00	$0.00

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 §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is Dr. Mayorga entitled to additional reimbursement for the service in question?

Findings

Dr. Mayorga is seeking reimbursement of $50.00 for incorporating specialist reports into a designated doctor examination. Per explanation of benefits dated April 2, 2019, the insurance carrier reimbursed the full amount requested subsequent to the request for medical fee dispute resolution. For this reason, the DWC finds that no further reimbursement is due.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	July 11, 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.