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
MAYORGA, GILBERT JR

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-20-1849-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 1, 2020

REQUESTOR'S POSITION SUMMARY

"In brief, line item 99456 W5 WP the charges were $800.00 for 2 units according to Texas Fee Guidelines. We only received $700.00. Therefore, we request that we be reimbursed as allowed by the Texas Fee Guideline for this line item, the additional amount of $100.00."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

"While the carrier did initially reimburse the provider only $700 under CPT code 99456 W5, on February 7, 2020 the carrier reprocessed the provider's bill and recommended additional reimbursement of $100. We are attaching a copy of that EOB. We are also attaching a copy of proof of payment which was issued on February 7, 2020 and endorsed by the provider. The carrier has also issued a payment of interest based upon an EOB dated April 9, 2020."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2019	Designated Doctor Examination 99456-W5-WP	$100.00	$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 (DWC). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is Gilbert Mayorga, Jr., M.D. entitled to additional reimbursement?

Findings

Dr. Mayorga is seeking an additional reimbursement of $100.00 for a designated doctor examination performed on April 24, 2019. Per submitted documentation, the insurance carrier reimbursed this amount in full on or about February 7, 2020. No further reimbursement is recommended.

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

		July 23, 2020
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 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.