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
TPS JOINT SELF INS FUNDS

MFDR Tracking Number
M4-20-2102-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
May 1, 2020

REQUESTOR'S POSITION SUMMARY

"As of this date, we have not been paid for the designed doctor evaluation."

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

"Check number 354373 in the amount of $1215.00 was issued on 08-27-2019 … CPT code 99456-W5-WP was inadvertently underpaid at $650.00. The carrier is recommending an additional $150 for impairment rating bringing total recommended allowance for 99456-W5-WP to $800. Reimbursement is $350 for MMI, $300 for IR of musculoskeletal upper extremity body area (left hand and left wrist); $150.00 for IR of musculoskeletal lower extremity body area (left knee)."

Response Submitted by: Novare LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2019	Designated Doctor Examination: 99456-W5-WP 99456-W8-RE 99456-SP	$1,500.00	$150.00

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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
   - 6498 – We are unable to process your bill until we receive a copy of your W-9 that is on file with the IRS. Additionally, the W-9 form must be signed and dated with the current date/year.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. What are the services considered in this dispute?
2. Is Gilbert Mayorga, M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Mayorga requested this dispute for reimbursement for a designated doctor examination that included determination of maximum medical improvement, impairment rating, return to work, and specialist reports.

   Per explanation of benefits dated August 23, 2019, the insurance carrier paid in full for the examination to determine the ability of the injured employee to return to work and the specialist reports. Therefore, these services will not be considered in this dispute.

   Dr. Mayorga billed $950.00 for the examination to determine maximum medical improvement and impairment rating of three body areas. The explanation of benefits dated August 23, 2019 indicates that the insurance carrier paid $650.00. In an explanation of benefits dated May 5, 2020, the insurance carrier paid an additional $150.00 after the request for medical fee dispute was filed, totaling $800.00. This service will be considered in this dispute.

2. The submitted documentation supports that Dr. Mayorga performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   Review of the submitted documentation finds that the requestor performed impairment rating evaluations of abrasions, the left wrist, and the left knee. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[3] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[4]

   The narrative for the examination states that Dr. Mayorga performed range of motion for the left wrist and left knee, which are musculoskeletal body areas. The documentation also shows that Dr. Mayorga assessed the abrasions according to Chapter 13, Table 2. The total MAR for the determination of impairment rating is $600.00.

   The total allowable reimbursement for the examination in question is $950.00. The insurance carrier paid $800.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[4] 28 TAC §134.250(4)(D)(v)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		August 18, 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.