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

Requester Name
MAYORGA, GILBERT JR

Respondent Name
CITY OF EL PASO

MFDR Tracking Number
M4-20-2343-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 22, 2020

REQUESTER'S POSITION SUMMARY

"On the bill line item 99456 W6RE is for $500.00, but we received only $250.00. Therefore we request that we be reimbursed the additional $250.00 as allowed by the Texas Fee Guideline."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

"The expenses for CPT code 99456-W6-RE billed @ $500.00 should have been paid in full. In error, payment was issued in the amount of $250.00. Our initial receipt of a reconsideration was on 5/13/2020 and on 5/22/2020, payment in the amount of $250.00 was issued."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2019	Designated Doctor Examination (99456-W6-RE)	$250.00	$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, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Mayorga is seeking additional reimbursement for an examination to determine the extent of the compensable injury.

The MAR for such examinations is $500.00.[1] Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100%, the second examination is reimbursed at 50%.[2] For this dispute, the MAR for the examination to determine extent of injury is $500.00.

Per explanation of benefits and check dated August 2, 2019, the insurance carrier paid $250.00 for the examination in question. Per explanation of benefits dated May 22, 2020, the insurance carrier paid an additional $250.00.

The DWC concludes that the evidence supports that the insurance reimbursed Dr. Mayorga in full for the examination in question. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester 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 requester is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 15, 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.

[1] 28 TAC §134.235

[2] 28 TAC §134.240 (2)