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
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-20-2346-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 22, 2020

REQUESTOR'S POSITION SUMMARY

"According to our records, the total bill was $715.00. We received $ 650.00. Line item 99456 SP for $50.00 was not reimbursed as allowed by the Texas Fee Guideline."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2019	Designated Doctor Examination (99456-SP)	$50.00	$50.00

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 submitted documentation does not include explanations of benefits for the specific service in question.

Issues

1. Did Hartford Casualty Insurance Company respond to the medical fee dispute?
2. Did Hartford Casualty Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Gilbert Mayorga, M.D. entitled to reimbursement for the service in question?

Findings

1. The Austin carrier representative for Hartford Casualty Insurance Company is Burns Anderson Jury Brenner. The representative was notified of this medical fee dispute on May 27, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Dr. Mayorga is seeking reimbursement for incorporating a specialist report in conjunction with a designated doctor examination for determination of impairment rating. The doctor argued that he had not received payment for this service.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[2]

   The greater weight of evidence presented to the DWC supports that the service in question was billed and received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the service in question.

3. Because the insurance carrier failed to raise any defense for non-payment of the service in question, Dr. Mayorga is entitled to reimbursement.

   When the designated doctor refers testing for non-musculoskeletal body areas to a specialist, the doctor bills this service using the appropriate MMI CPT code with modifier "SP."[3]

   Dr. Mayorga referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for the brain. The use of this report is noted in the narrative. Therefore, the correct MAR for this service is $50.00.[4] This amount 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 $50.00.

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 $50.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250 (4)(D)(iii)(I)
[4] 28 TAC §134.250 (4)(D)(iii)(I)

Authorized Signature

		August 31, 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.