TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requester Name**
MAYORGA, GILBERT JR

**Respondent Name**
HARTFORD CASUALTY INSURANCE CO

**MFDR Tracking Number**
M4-20-2818-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
July 31, 2020

## *REQUESTER'S POSITION SUMMARY*

"Please find attached original report and supporting documentation for your reconsideration."

**Amount in Dispute:** $400.00

## *RESPONDENT'S POSITION SUMMARY*

"As evidenced in the attached EOB, on September 4, 2019, Hartford issued payment for the disputed amount."

**Response Submitted by:** Burns Anderson Jury & Brenner

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 6, 2019 | Designated Doctor Examination (99456-NM-W5 and 99456-SP) | $400.00 | $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.C. entitled to additional reimbursement?

**Findings**

Dr. Mayorga is seeking $400.00 for a designated doctor examination to determine maximum medical improvement and incorporating a specialist's report. Based on evidence presented to the DWC, the insurance carrier paid the disputed amount in full via check number 88361473. 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 20, 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**.