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
ACCIDENT FUND GENERAL INSURANCE

MFDR Tracking Number
M4-20-2876-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
August 7, 2020

REQUESTER'S POSITION SUMMARY

"On line item 99456-W5-WP there were four units involved, and according to the Texas Fee Guideline we should have been paid $1100.00. We were reduced $150.00 and were only paid $950.00. Therefore, we request that we be reimbursed the additional $150.00 as allowed by the Texas Fee Guideline."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

"Payment in the amount of $150.00 was issued to the provider, Gilbert Mayorga Jr. On 07/13/2020, check number 101507019."

Response Submitted by: Accident Fund Insurance Company of America

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2019	Designated Doctor Examination (99456-W5-WP)	$150.00	$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?

Findings

Dr. Mayorga is seeking an additional $150.00 for a designated doctor examination to determine maximum medical improvement and impairment rating. Based on evidence submitted to the DWC, the greater weight of

evidence supports that the insurance carrier paid the disputed amount via check number 10150719. 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 21, 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.