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
AMERICAN CASUALTY CO OF READING

MFDR Tracking Number
M4-20-2909-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
August 13, 2020

REQUESTOR'S POSITION SUMMARY

"In brief, we have not been paid to date for the service provided."

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Response dated August 31, 2020: "Carrier submits the attached Payment History indicting that a payment in the amount of $365.00 was originally issued to Med-Loss Inc. on July 2, 2020. Additionally, payments of $635.00 and $26.72 were issued to Med-Loss Inc. on August 26, 2020."

Subsequent response dated November 6, 2020: "Re-issued payments were issued on 10/05/20 in the amount of $1,000.00 via ck#107766333 and an interest payment was re-issued on 10/07/20 in the amount of $26.72 via ck#107771495."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2019	Designated Doctor Examination (99456-W5-WP; 99456-SP)	$1,150.00	$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). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issue

Is Gilbert Mayorga, M.D. entitled to reimbursement?

Findings

Dr. Mayorga is seeking reimbursement for a designated doctor examination, stating he had not received payment. The insurance carrier provided evidence that it reissued a payment totaling $1,000.00 for the services in question and $26.72 for interest.

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 Dr. Mayorga performed impairment rating evaluations of the right shoulder, wrist, and bilateral hands with range of motion testing; the right hip; a scalp laceration; and concussion. 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 total MAR for the determination of impairment rating is $750.00.

Examination	AMA Chapter	§134.250 Category	Applicable 28 TAC Rule	Reimbursement Amount
Maximum Medical Improvement			134.250 (3)(C)	$350.00
IR: Shoulder, Wrist, Hands	Musculoskeletal System	Upper Extremities	134.250 (4)(C)(ii)(II)	$300.00
IR: Right Hip		Lower Extremities		$150.00
IR: Scalp Laceration	Skin	Body Structures	134.250 (4)(D)(v)	$150.00
IR: Head Contusion	Nervous System	Body Systems	134.250 (4)(D)(v)	$150.00
Incorporating Specialist Report			134.250 (4)(D)(iii)(I)	$50.00
Total MMI				**$350.00**
Total IR				**$750.00**
Total Exam				**$1,150.00**

The total allowable reimbursement for the examination in question is $1,150.00. The insurance carrier paid $1,000.00. 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.

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.

[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)

Authorized Signature

		January 8, 2021
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.