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
M4-20-2910-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 13, 2020

REQUESTER'S POSITION SUMMARY

"In brief, we were not paid for line item 99456 SP, which was required in order to prepare the report. Therefore, we request that we be reimbursed as allowed by the Texas Fee Guideline for this line item the amount of $50.00."

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
August 21, 2019	Designated Doctor Examination (99456-SP)	$50.00	$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).

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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

Issues

1. Did the City of El Paso respond to the medical fee dispute?
2. Is Gilbert Mayorga, Jr., M.D. entitled to additional reimbursement for the examination in question?

Findings

1. The Austin carrier representative for the City of El Paso is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on August 20, 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 additional testing into the designated doctor examination. Dr. Mayorga billed this service using procedure code 99456-SP.

   Modifier "SP" is added to procedure code 99456 when the examining doctor incorporates a specialist report into **the determination of impairment rating for a non-musculoskeletal body area**.[2] Dr. Mayorga provided no evidence to support that he referred the injured employee to a specialist and incorporated that report in the final determination of an impairment rating of a non-musculoskeletal body area.

   No additional reimbursement is recommended for the service in question.

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 §133.307(d)(1)

[2] 28 TAC §134.250 (4)(D)(iii)