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

Requestor Name
MAYORGA, GILBERT JR

Respondent Name
ALLMERICA FINANCIAL BENEFIT INSURANCE CO

MFDR Tracking Number
M4-21-0774-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 15, 2021

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

"After reviewing the additional information submitted by the provider, we have determined no additional money is owed … At this time it appears the dispute has been resolved by way of the original bill that was processed on 6/3/2020 … in the amount of $350.00"

Response Submitted by: Medata Service Operations

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2020	Designated Doctor Examination (99456-W5-WP)	$650.00	$300.00

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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
   - 16 – Claim/service lacks information or has submission/billing error(s).

- W3 – The Benefit for this Service is included in the payment /allowance for another service/procedure that has been performed on the same day.
- 28 – The reduction was made for reasons indicated in note below or on the attached note or letter.
- Notes – "Based on the documentation attached it appears this bill has seen processed and paid accordingly. No additional monies are owed."
- @G – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

Is Gilbert Mayorga, Jr., M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Mayorga is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Mayorga performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

The submitted documentation supports that Dr. Mayorga provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right middle finger. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

The total allowable amount for the examination in question is $650.00. The insurance carrier paid $350.00. An additional reimbursement of $300.00 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 $300.00.

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 $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		March 18, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.