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
CITY OF AUSTIN

MFDR Tracking Number
M4-21-0776-01

Carrier's Austin Representative
Box Number 43

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: $850.00

RESPONDENT'S POSITION SUMMARY

"With further review no allowance is being recommended based on findings of payment being previously made to the billing provider-Med Loss Inc under bill review# 11235688 with check number 397452 released on 02/268/20. Check was cashed on 03/17/20 at Prosperity Bank pay o MED Loss Inc."

Response Submitted by: Sedgwick

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2020	Designated Doctor Examination (99456-NM-W5)	$350.00	$0.00
January 29, 2020	Designated Doctor Examination (99456-W8-RE)	$500.00	$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, Jr., M.D. entitled to additional reimbursement for the examinations in question?

Findings

Doctor Mayorga is seeking additional reimbursement for a designated doctor examination performed on January 29, 2020. Per explanation of benefits dated February 24, 2020, the requested amount was paid in full. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor 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 requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		March 29, 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.