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
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-21-0906-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 3, 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

"Our bill audit company has determined additional monies are owed in the amount of $665.00. Interest in the amount of $0.00 has been issued. Attempted to contact the facility … to advise of an overpayment in the amount of $650.00 for the same DOS …"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2020	Designated Doctor Examination (99456-W5-WP)	$650.00	$650.00

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 submitted documentation did not include explanations of benefits.

Issues

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

Findings

Dr. Mayorga is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. Gallagher Bassett, on behalf of the XL Specialty Insurance Company, stated that it had overpaid the bill in the amount of $650.00.

The insurance carrier failed to provide any evidence of payment. Therefore, Dr. Mayorga is entitled to reimbursement.

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 of the left hand with range of motion testing. 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 reimbursement for the examination in question is $650.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $650.00.

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 $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 25, 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.