



# 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**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-21-1130-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

March 8, 2021

### REQUESTOR'S POSITION SUMMARY

"The insurance carrier has denied payments stating that it was beyond the 95<sup>th</sup> day. However, there were extensions and extenuating circumstances of the COVID-19 crisis ..."

**Amount in Dispute:** \$1,500.00

### RESPONDENT'S POSITION SUMMARY

"The requestor billed \$1,500.00; Texas Mutual paid \$1515.00, plus interest \$21.25."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2020	Designated Doctor Examination (99456-W5-WP, 99456-W6-RE, 99456-SP)	\$1,500.00	\$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 examination in question?

#### **Findings**

Dr. Mayorga is seeking additional reimbursement for a designated doctor examination performed on March 24, 2020. Evidence submitted by the insurance carrier supports that it paid the full amount requested. Dr. Mayorga is not entitled to additional reimbursement for this examination.

**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**

		June 17, 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.**