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
ACCIDENT FUND GENERAL INSURANCE CO

MFDR Tracking Number
M4-21-1131-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
March 8, 2021

REQUESTOR'S POSITION SUMMARY

"The insurance carrier has denied payments stating that it was beyond the 95th day. However, there were extensions and extenuating circumstances of the COVID-19 crisis, and … patients were not allowed to be seen by any healthcare provider for the Texas Department of Insurance until July of 2020, and patients were evaluated, and reports were prepared and submitted to the carrier."

Amount in Dispute: $2,025.00

RESPONDENT'S POSITION SUMMARY

"After reviewing the dispute, Accident Fund has elected to pay $1,875.00 of the $2,025.00 alleged to be in dispute."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2020	Designated Doctor Examination (99456-W5-WP)	$1,100.00	$1,100.00
March 24, 2020	Designated Doctor Examination (99456-W6-RE)	$500.00	$500.00
March 24, 2020	Designated Doctor Examination (99456-W7-RE)	$250.00	$250.00
March 24, 2020	Designated Doctor Examination (99456-W8-RE)	$125.00	$125.00
March 24, 2020	Specialist Report (99456-SP)	$50.00	$50.00
	Total	$2,025.00	$2,025.00

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 §134.235 sets out the fee guidelines for examinations to determine extent of injury, disability, and return to work.
3. 28 Texas Administrative Code §134.240 sets out the fee guidelines for designated doctor examinations.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
5. The submitted documentation did not include explanations of benefits from either party.

Issues

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

Findings

Dr. Mayorga is seeking reimbursement for a designated doctor examination performed on March 24, 2020.

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

Review of the submitted documentation finds that Dr. Mayorga performed impairment rating evaluations of spine, upper extremity, and lower extremity with range of motion testing, and mild traumatic brain injury. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[3] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[4] The total MAR for the determination of impairment rating is $750.00.

The submitted documentation indicates that Dr. Mayorga performed an examination to determine extent of the compensable injury, if disability was related to the compensable injury, and the ability to return to work. The MAR for such examinations is $500.00.[5] Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100%, the second examination is reimbursed at 50%, and additional examinations are reimbursed at 25%.[6]

For this dispute, the MAR for the examination to determine extent of injury is $500.00. The examination to determine disability is $250.00. The examination to determine return to work is $125.00.

Submitted evidence supports that Dr. Mayorga referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for mild traumatic brain injury. The use of this report is noted in the narrative. Therefore, the correct MAR for this service is $50.00.[7]

The total allowable reimbursement for the examination in question is $2,025.00. The insurance carrier stated it paid $1,875.00 via check number 101858076 on March 19, 2021. However, no evidence was submitted to support this payment. Therefore, the DWC recommends reimbursement of $2,025.00 for the examinations in question.

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 $2,025.00.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[4] 28 TAC §134.250(4)(D)(v)
[5] 28 TAC §134.235
[6] 28 TAC §134.240 (2)
[7] 28 TAC §134.250 (4)(D)(iii)

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 $2,025.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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.