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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-1132-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 8, 2021

REQUESTOR'S POSITION SUMMARY

"In brief, the patient was seen for a designated doctor evaluation at the request of the Texas Department of Insurance, Division of Workers Compensation. The report was prepared and submitted in a timely fashion which was received by the carrier. However, the insurance carrier denied payment based on the fact that I was not in the network to provide services for the carrier. However, … the Texas Administrative Code does not allow an in-network member to serve as a designated doctor for the carrier."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

"The carrier is reprocessing the provider's bill and will be issuing payment pursuant to the Medical Fee Guidelines. It appears that the provider is entitled to reimbursement of $350 for the MMI portion of the exam, $300 for range of motion for one of the body areas and is entitled to $150 for each of the other two body areas."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2020	Designated Doctor Examination (99456-W5-WP)	$950.00	$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 reimbursement for a designated doctor examination performed on March 12, 2020. Per explanation of benefits dated March 24, 2021, the insurance carrier paid the requested amount 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

		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.