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
TPS JOINT SELF INS FUNDS

MFDR Tracking Number
M4-21-1133-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
March 8, 2021

REQUESTOR'S POSITION SUMMARY

"In brief, we have not been paid to date for the services provided."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

"The carrier received the bill from the Med-Loss, Inc on 04-08-20 and issued payment in the amount of $850.00 to Med-Loss LLC on 04-15-20, check number 126827 … On 01-19-21, the claim adjuster received a call from the provider stating they had not received check 126827. The healthcare provider verified their billing address … TPS issued check 129243 in the amount of $850.00 … The carrier received a request for reconsideration on March 3, 2021. No additional allowance was recommended as the carrier had already timely and correctly paid $850.00 to the healthcare provider … Both checks were mailed to the address that appears on the CMS 1500 that was verified to be correct by the healthcare provider."

Response Submitted by: Novare LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2020	Designated Doctor Examination (99456-NM-W5 and 99456-W8-RE)	$850.00	$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 services in question?

Findings

Dr. Mayorga is seeking reimbursement for a designated doctor examination performed on March 25, 2020. Evidence submitted by the insurance supports that it reimbursed the services in full on or about April 15, 2020, and reissued payment in full on or about January 20, 2021. 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 9, 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.