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
M4-21-1134-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 8, 2021

REQUESTOR'S POSITION SUMMARY

"We were paid $950.00 which is not according to the Texas Fee Guidelines. We were underpaid by $150.00. Therefore, we request that we be paid the additional $150.00 for the additional body area that was not reimbursed in the original payment …"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

"According to the following research explained below, Texas Mutual concluded that an overpayment was made by the carrier, therefore the additional $150.00 is not warranted. Dispute date of service 3/18/2020 is the second exam completed for the same body parts requested per DWC 32 documentation. The first exam Dr. Mayorga completed was on 11/21/2019, he was paid $800.00 for the same body parts … Billing and documentation submitted confirms Dr. Mayorga completed the MMI exam and assigned the IR rating, however documentation does not support that he completed DRE/ROM on 3/18/2020, rather he addresses DRE/ROM from the 11/21/2019 exam date … Additionally, billing for 5 units for CPT code 99456 is not supported."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2020	Designated Doctor Examination (99456-W5-WP)	$150.00	$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).

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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

Is Dr. Mayorga entitled to additional reimbursement?

Findings

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 the cervical spine with range of motion testing and a head contusion. Dr. Mayorga stated that the chest wall contusion was a non-ratable condition, and no impairment was assigned, therefore this body area is not eligible for reimbursement. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[3] The total MAR for the determination of impairment rating is $450.00.

The total reimbursement for this examination is $800.00. The insurance carrier reimbursed $950.00. 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

		May 13, 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.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(D)(v)