

LUIS M GARCIA, MD  
2390 CENTRAL BLVD, SUITE M  
BROWNSVILLE, TEXAS 78520-8717  
TEL: (956) 574-9096  
FAX: (956) 541-8418

## FAX TRANSMITTAL

TO: Prominence Health Plan  
COMPANY/DEPT NAME:  
ATTN: Appeals  
FAX: 775-770-9004

FROM: REBECCA S GARCIA

REF: M000082196  
PAGES:       

Martha Guerrero  
CPT 88341 and 88342

## CONFIDENTIALITY NOTE

The information accompanying this facsimile is confidential and/or legally privilege and only the use of the individual named on the cover sheet. If you are not the intended recipient, or the employee or agent responsible to deliver the intended receipt, you are hereby notified that any disclosure, copying, distribution, dissemination or the taking of any action in reliance upon the contents of this facsimile in error, please telephone this office immediately so that we can arrange for the return of the documents at no costs to you.

\*\*\*

The Health Insurance Portability and Accountability Act of 1996 or (HIPPA) require that all patient information be considered protected health information. Protected health information is personal and sensitive information related to a patient's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization.

You, the recipient, are obligated to maintain it in a secure and confidential manner. Unauthorized redisclosure to maintain confidentiality could subject you to fines and other penalties described in state and federal law.

\*\*\*

Luis M. Garcia, MD  
2390 Central Blvd., Suite M  
Brownsville, Texas 78520  
Tel:( 956) 574-9096

August 26, 2025

Prominence Health Plan  
Department of Claims Appeals  
1510 Meadow Wood Lane  
Reno, Nevada 89502

NPI 1417991324  
Member: M A (Marth) Guerrero de Salomon  
DOB: 2/23/1959  
DOS: 06/25/2025  
Account: 7457690  
Claim: 25218E00718  
*ID M000082196*  
Dear Appeals Department:

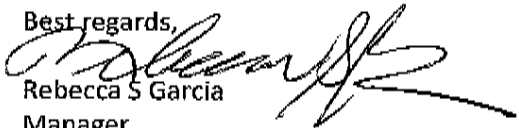
I am appealing a wrongfully denied claim for two procedures, 88342 and 8834. The patient had these procedures preformed at Valley Baptist Medical Center. The authorization that was obtained by the referring provider, Dr. Kenneth Ewane was intended for a different facility, Columbia Valley Regional Medical and not the facility where the patient had her service preformed.

I am appealing for payment on both 88342 and 88341 and request that these codes be re-processed. The patient had her biopsy performed through Lazer guided imaging in radiology at Valley Baptist Medical Center by the radiologist, Dr. Perami-Neto. The biopsy was then sent to the residing pathologist, Dr. Luis M Garcia, for evaluation. Dr Garcia preformed the special staining necessary for cancer staging, to which cpt code used were 88341 and 88342.

Dr Garcia provided a necessary service for the patient. Ms. Guerrero provided the pre-certification number 2506041000584953, at time of hospital admit. Unfortunately, the patient had authorization for another facility and not the one to which she registered.

If you have any questions, please feel free to contact me at 956-574-9096 at your earliest convenience.

Best regards,

  
Rebecca S Garcia  
Manager

## ePayment Transmittal

MATCH TO  
PAYMENT ID: 727597330**Prominence<sup>®</sup>**  
**Health Plan**  
**Medicare Advantage**570 Carillon Pkwy. Suite 500,  
St. Petersburg, FL 33716LUIS M GARCIA, MD  
2390 CENTRAL BLVD  
BROWNSVILLE, TX 785208717

Payment Date: 08/20/2025

Claim Payor:  
Prominence Health Plan  
Medicare Advantage  
C/O Claims Processing  
P.O. Box 50190  
Sparks, NV 89435  
Customer Service: (877) 700-3088Electronic Claims:  
80095Claim Questions ? Please refer to the Payor's Customer  
Service Phone Number as noted ABOVE.

Provider's TIN: 74-2698361

PT: GUERRERO DE  
SALOMON, M A

PT.ACCT: 7457690

PLAN ID: M00008219600

CLAIM #: 25218E00718

| Date of Service   | Procedure                           | Billed Amount | PPO Discount | Non Covered | Other Coverage | Deductible Co-Pays | Patient Resp. | Paid    | Ref.          |
|-------------------|-------------------------------------|---------------|--------------|-------------|----------------|--------------------|---------------|---------|---------------|
| 08/26/25-08/25/25 | 88305: TISSUE EXAM BY PATHOLOGIST   | \$280.00      | \$246.00     | \$0.68      | \$0.00         | \$0.00             | \$0.00        | \$33.32 | 253,45        |
| 08/25/25-08/25/25 | 88342: IMMUNOHISTO ANTIB 1ST STAIN  | \$200.00      | \$200.00     | \$0.00      | \$0.00         | \$0.00             | \$0.00        | \$0.00  | 197,M0019,M62 |
| 08/25/25-08/25/25 | 88341: IMMUNOHISTO ANTIB ADDL SLIDE | \$1,000.00    | \$1,000.00   | \$0.00      | \$0.00         | \$0.00             | \$0.00        | \$0.00  | 197,M0019,M62 |
| Totals:           |                                     | \$1,480.00    | \$1,446.00   | \$0.68      | \$0.00         | \$0.00             | \$0.00        | \$33.32 |               |

Reference: 253  
45  
197  
M0019  
M62Sequestration - Reduction Federal Spending  
Charges exceed your contracted/ legislated fee arrangement.  
Precertification/authorization/notification/pre-treatment absent.  
Benefit Requires Prior Authorization  
Missing/incomplete/invalid treatment authorization code.

PT: ESPARZA, LYDIA

PT.ACCT: 7466030

PLAN ID: M00008349800

CLAIM #: 25220E00884

| Date of Service   | Procedure                         | Billed Amount | PPO Discount | Non Covered | Other Coverage | Deductible Co-Pays | Patient Resp. | Paid    | Ref.   |
|-------------------|-----------------------------------|---------------|--------------|-------------|----------------|--------------------|---------------|---------|--------|
| 07/01/25-07/01/25 | 88304: TISSUE EXAM BY PATHOLOGIST | \$195.00      | \$184.62     | \$0.21      | \$0.00         | \$0.00             | \$0.00        | \$10.17 | 253,45 |
| Totals:           |                                   | \$195.00      | \$184.62     | \$0.21      | \$0.00         | \$0.00             | \$0.00        | \$10.17 |        |

Reference: 253  
45Sequestration - Reduction Federal Spending  
Charges exceed your contracted/ legislated fee arrangement.

Total Paid By Payor

Total: \$43.49

For questions regarding the claim or benefit determination, please contact the Payor indicated in the box at the upper right hand corner of this EOP.