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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR GEOFFREY A FUNK
3701 JUNIUS STREET CS 11 G006
DALLAS TX 75246

Respondent Name
SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-13-0903-01

MFDR Date Received
DECEMBER 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please find the enclosed request for medical fee dispute resolution. Our claimw as originally dneid per Rule 133.20(e)(2), which states a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. The decision to deny the claim was upheld on appeal. Services were provided by Elisabeth Frei, M.D., who is a resident in training, under the direct supervision of Geoffrey Funk, M.D., a fully licensed health care provider. Dr. Funk billed for this service and should be paid."

Amount in Dispute: $120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Rule states that a supervisor can submit billing if they were supervising 'an **unlicensed** individual…' **Doctor Elisabeth Frei** is a licensed medical provider capable of submitting her own billing. Therefore, the 'direct supervision' argument is without merit."

Response submitted by: White Espey P.L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2012	CPT Code 99231-24	$120.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, 33 TexReg 626, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.

3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the rule for medical bill submission by a Health Care Provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 24-Unrelated E&M Service, Same Physician.
   - B20-Srvc partially/fully furnished by another provider.
   - 193-Original payment decision maintained.

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the disputed services were denied reimbursement because "B20-Srvc partially/fully furnished by another provider."

   The disputed service is listed as CPT code 99231-24.

   CPT code 99231 is defined as "Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit."

   The requestor appended modifier "24-Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period" to CPT code 99231.

   28 Texas Administrative Code §133.20(e)(2) states "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The respondent maintains the denial of reimbursement based upon "the Rule states that a supervisor can submit billing if they were supervising 'an **unlicensed** individual…' **Doctor Elisabeth Frei** is a licensed medical provider capable of submitting her own billing. Therefore, the 'direct supervision' argument is without merit."

   The requestor contends that reimbursement is due because "Services were provided by Elisabeth Frei, M.D., who is a resident in training, under the direct supervision of Geoffrey Funk, M.D."

   The Division reviewed the submitted medical records and supporing documentation and finds the following:

   - Dr. Geoffrey A. Funk is listed in box 31 of the medical bill.
   - The Evaluation and Management report is signed by Dr. Elisabeth Frei.
   - Dr. Elisabeth Frei is a licensed health care provider in Texas.
   - Dr. Geoffrey A. Funk did not provide the disputed service.

   The Division concludes that per 28 Texas Administrative Code §133.20(e)(2), reimbursement is not recommended because the rule specifies that the medical bill must be submitted by the licensed health care provider who renderered the service; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/17/2014
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 28 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.