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
RGV Preventative Care, Inc

Respondent Name
Texas Builders Insurance Co

MFDR Tracking Number
M4-13-2139-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $551.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per Rule 133.20(e)(2) 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. Per reports, Anna Lee Dixon, ANP and A. Kapilivsky, MD licensed, rendering HCPs. As Audrey Jones, DO was not supervising an unlicensed HCP, we respectfully submit that the denial for services are correct and that no further allowance is recommended as such. … As HCP did not address (4) above, we respectfully submit that the form is not considered to be complete and that no further allowance is recommended."

Response Submitted by: Parker & Associates LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14 and September 18, 2012	99203, 99080, 73130, 73110, 99213, 99080	$551.00	$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 §133.20 sets out the guidelines of medical bill submission by health care providers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 185 – Denied, provider not eligible to perform service
   - B20 – Srvc partially / fully furnished by another provider
   - 193 – Original payment decision maintained

Issues

1. Did the requestor support Division guidelines met when claim was submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as B20 – "Srvc partially / fully furnished by another provider." 28 Texas Labor Code §§133.20(d) states, "The health care provider that provided the health care shall submit its own bill, unless:(1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service; (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill; (3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or (4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill." Review of the submitted documentation finds the carrier's denial is supported.
2. The requestor has failed to show one of the four exceptions to Division rules was met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

Signature	Medical Fee Dispute Resolution Officer	August , 2014 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.