



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

ELITE HEALTHCARE FORT WORTH

Respondent Name

AMERICAN HALLMARK INSURANCE CO

MFDR Tracking Number

M4-14-0758-01

Carrier's Austin Representative

Box Number: 01

MFDR Date Received

November 4, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. Sent reconsideration in explaining that our physical therapist did not treat the patient, but simply did a physical therapy evaluation per the treating provider Dr. Lopez. Still received denial stating furnished by another provider. I have indicated the change on the claim form to show the physical therapist information and hope to clear this up and get paid. I'm taking the next step to get the rest of these claims paid and sending all documentation to MDR..."

Amount in Dispute: \$119.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier denied payment on the basis of Reason Code B20 – Service partially/fully furnished by another provider. The bill was then resubmitted for appeal with Steve Silvey, PT listed as the provider who rendered the service in Box 31.... The carrier maintained its dispute of payment on the reconsideration EOR... Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care. Per report, Steve Silvey, PT, was the rendering HCP, and he is a licensed HCP, so the bill submitted under the name and license number of Michael Lopez, D.C was properly denied. In summary, the carrier respectfully takes the position that its original audit and subsequent reconsideration were done correctly and consistently, and a corrected billing has been submitted only with its MDR request. Therefore, no payment should be ordered."

Response Submitted by: Parker & Associates, LLC

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| January 22, 2013 | CPT Code 97001 | \$119.68 | \$119.68 |

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 for medical bill submission by the health care

provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - B20 – Srvc partially/fully furnished by another provider.
 - 168 – No additional allowance recommended.
 - GP – Service delivered under OP PT care plan.
 - 193 – Original payment decision maintained.

Issues

1. Did the requestor bill the services in dispute correctly?
2. Did the requestor submit a request for reconsideration and is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.20(e)(2), states that 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. Review of the documentation submitted by the parties finds that the initial bill incorrectly listed the referral doctor as the health care provider that provided the health care. The insurance carrier properly denied the service using denial code “B20 – Srvc partially/fully furnished by another provider.” The health care provider corrected the bill to reflect the correct health care provider and resubmitted the bill for payment.

28 Texas Administrative Code §133.307(c)(2)(J) states that requests for MFDR shall be filed in the form and manner prescribed by the division; requestors shall file two legible copies of the request with the division and the requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions). Review of the requestors’ documentation finds that the requestor has submitted the corrected billing which is also stamped “Request for Reconsideration.” The respondent submitted copies of the original billing and the corrected billing.

2. 28 Texas Administrative Code § 133.250(d)(1) states that the request for reconsideration shall reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill. A review of documentation submitted by both parties finds that the health care provider did not change billing codes, dates of service nor the dollar amounts as originally billed; therefore, reimbursement in accordance with 28 Texas Administrative Code 134.203(c)(1) is recommended as follows: $((55.3 \div 34.023) \times \$73.88) = \$120.08$. The requestor in the dispute has requested reimbursement in the amount of \$119.68; Therefore, reimbursement in the amount of \$119.68 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$119.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$119.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 23, 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.