



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

Richard Davis

Respondent Name

Insurance Co of the State of PA

MFDR Tracking Number

M4-14-2431-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...bills resubmitted with corrections and EOB sent stats no pay as duplicate bill. Bills should be paid."

Amount in Dispute: \$1,870.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...it is the carrier's position that the bill was denied correctly. The original bill was denied for several reasons. First, the referring provider license was not provided and the NPI was missing and/or was invalid. Additionally the required function-related G-codes and/or modifiers were not used or documented on the bill. A request was made to resubmit the bill with this mandatory information. Upon receiving another bill from the provider, ICN 26140660381500, it was noted the provider failed to submit the referring provider license and the correct modifiers were not keyed; therefore the second submission was determined to be a duplicate."

Response Submitted by: AIG, P.O. Box 25794, Shawnee Mission, KS 66225

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2014 through February 18, 2014	Physical Therapy Services	\$1,870.00	\$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 §133.10 sets out requirements related to billing forms and formats.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Referring provider license number is missing or invalid. Please resubmit bill with this information included
 - 18 – Duplicate claim/service

Issues

- 1. Did the requestor submit the medical claim as required by Division rules?
- 2. Is the requestor entitled to reimbursement?

Findings

- 1. The carrier denied the services in dispute as, "Referring provider license number is missing or invalid. Please resubmit bill with this information included" and 18 – "Duplicate claim/service." 28 Texas Labor Code §133,10 (f) states "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');" Review of the medical claim finds this field was left blank. The carrier's denial is supported.
- 2. The medical claim did not meet the requirements of Division guidelines therefore, 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	December 18, 2014 Date
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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.