



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

Physicians Center

Respondent Name

Indemnity Insurance Co of North

MFDR Tracking Number

M4-15-0448-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "this date of service is prior to new rules that took affect 04/01/14."

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due. ...Denial is appropriate."

Response Submitted by: Gallagher Bassett, 6404 International Parkway, Suite 2300, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 23, 2013 February 25, 2014	99213, 99080 -25 99213, 99080 -25	\$250.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.10 sets out requirements related to billing forms and formats.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
 - 18 – Duplicate claim/service

Issues

- Did the requestor support submission of a complete bill?
- Is the requestor entitled to reimbursement?

Findings

- The requestor states, "this date of service is prior to new rules that took affect 04/01/14." 28 Texas Labor

Code §133.10 (f) states in pertinent part, "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. (U)rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); (V)rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;" Review of the Texas Register finds:

- a. TITLE 28 INSURANCE PART 2 TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION CHAPTER 133 GENERAL MEDICAL PROVISIONS SUBCHAPTER B HEALTH CARE PROVIDER BILLING PROCEDURES RULE §133.10 Required Billing Forms/Formats ISSUE 02/18/2011 ACTION Final/Adopted (I)This section is effective August 1, 2011.

The requestor's position is not supported as the requirements of completing field 24j of the CMS-1500 when the rendering provider is not the billing provider listed in CMS-1500/field 33, was in effect on the date of the disputed services. The Division finds a complete bill was not submitted.

2. Requirements of Rule 133.10 have not been 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

February 23, 2015

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.