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
Trinity Orthopedics

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-15-1925-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
February 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The bills are submitted in the name of the licensed HCP that provided direct supervision to Kayla Holmes P.T.A."

Amount in Dispute: $383.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, Trinity Orthopedics PA is not entitled to reimbursement for physical medicine treatment and services in the amount of $383.00 billed on 11/25/14 using CPT code(s) 97110, 97012 based on health care provider billing requirements set forth under §133.10(f)(1)(U-V), §133.20(d)(2) and subparagraph (e)(2), and division medical billing data collection requirements. "

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014	97110, 97112	$383.00	$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 requirements related to billing forms and formats
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B20 - Srvc partially/fully furnished by another provider
   - 193 – Original payment decision maintained

Issues

1. Did the requestor submit the medical claims in compliance with Division guidelines?
2. Did the requestor support their position statement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as B20 – "Srvc partially/fully furnished by another provider." 28 Texas Labor Code §133.20 (e) states in pertinent part, "A medical bill must be submitted: (1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and (2) 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 medical bill finds;
    a. NPI found in Box 24J is 1306938683 for Mr. Brian David Read
    b. Health care provider that signed "Trinity Rehabilitation – Lower Extremity Daily Note" was Kayla Holmes, PTA TX License 2104409

   The Division finds the Carrier's denial is supported.
2. 28 Texas Administrative Code §134.203 (7) states in relevant part, "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program". The Division notes the requestors position that Medicare requirement as outlined in Rule 134.203 (7) (b), "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;…" requires that a bill be submitted under the Physical therapist license not the Physical therapist assistant license. However as stated in Rule134.203 (7), when conflict occurs between Medicare and the Division of Workers Compensation Division rules, the Divisions rules do take precedence.
3. The provisions of Rule 133.20 were not 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

		March , 2015
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**.