



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Dralves G. Edwards, DO

Respondent Name

Fidelity and Guaranty Insurance

MFDR Tracking Number

M4-15-2379-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Bassett on January 8, 2014, this request was in response to a nonpayment of the \$650.00 for the Designated Doctor Exam performed on June 20, 2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and the review has been finalized. Our bill audit company has determined no further payment is due. Please see below for rationale behind their denial.

DOS: 6/20/2014

Per TX guidelines:

http://www.tdi.texas.gov/wc/rules/documents/wcrules.pdf

Subchapter B – Health Care Provider Billing Procedures
§133.10 Required Billing Forms/Formats.

(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');

(L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number;

Provider provided Dallas DWC as referring physician and advises the provider and no NPI was provided.

Per prior response from state reporting:

According to TX, that is not a valid referring provider and should not be billed. See the below to confirm a valid referring provider. Communication should be made with the provider they are not billing correctly.

Texas Labor Code Section 401.011 (22) which defines health care provider
CMS 1500 Instructions

eBill Rules <http://www.tdi.texas.gov/wc/ebill/index.html>

The EDI Guide <http://www.tdi.texas.gov/wc/edi/index.html>

Per review of the information provided Referring provider name does not appear to be a requirement for billing however if one is provide then NPI is also required. Per review of the attached the provider is still providing the referring provider as Dallas DWC with no NPI. Denial is appropriate.”

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2014	Designated Doctor Examination (MMI/IR)	\$650.00	\$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
5. Texas Labor Code §401.0041 sets out the general requirements regarding Designated Doctor Examinations.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 20 – (206) National provider identifier – missing.
 - F624 – Not defined as required by 28 Texas Administrative Code §133.240.

Issues

1. Are the insurance carrier’s reasons for denial or reduction of payment supported?
2. What is the correct Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 20-(206) – “National provider identifier – missing.” In their position statement, the insurance carrier further explains this denial, stating that the Dallas DWC is “not a valid referring provider and should not be billed...[but] if one is provide[d] then NPI is also required.”

28 Texas Administrative Code (TAC) §133.10 (f)(1) states, in relevant part, “The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (J) name of referring provider **or other source** is required when another health care provider referred the patient for the services; No qualifier indicating the role of the provider is required (CMS-1500, field 17); (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'); (L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required **when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number**” [emphasis added].

Review of the submitted information finds that the requestor submitted a CMS-1500 with Dallas DWC listed as the referring provider or **other source**, as permitted by 28 TAC §133.10 (f)(1)(J). Further, because the referral source is not eligible to receive an NPI number, none is required, per 28 TAC §133.10 (f)(1)(L). The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the lumbar spine to find the Impairment Rating. Therefore, the correct MAR for this examination is \$300.00.

3. The total allowable for the disputed services is \$650.00. The insurance carrier has paid \$0.00. Therefore, a reimbursement of \$650.00 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 \$650.00.

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 \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	May 13, 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, 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 MFDR 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.