



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Louis F. Puig, MD

Respondent Name

Insurance Company of the State of PA

MFDR Tracking Number

M4-15-2508-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Occupational Medical Care is disputing AIG/CHARTIS on the above claim. We request a resolution based on the fact that we never received an Explanation of Benefits for the above patient. When the insurance company was contacted they claimed they never received the claim, yet our electronic clearing house website that the bills were forwarded to them in a timely matter. Please find the attached report from our electronic billing website to show that the bills were sent over and received during the 95-day range after date of service.

In accordance of the Workers' Compensation Rules & Regulations, we believe this is a compensable injury and should have been reimbursed within 30 days of the electronic filing to avoid late fees."

Amount in Dispute: \$197.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Insurance Company of the State of PA has reviewed the Medical Fee Dispute Resolution Request (DWC-60). It is the Carrier's position that there is no money owed to the requestor, Louis F. Puig for the 4/1/2014 and 6/3/2014 dates of service.

It appears that the bill was only submitted one time (4/1/14 for medicine) and one time for the 6/3/2014 bill. I have printed out the EOB's for your review. We did pay an office visit on 4/15/2014 which I have attached.

The 6/3/14 bill was denied on 7/22/2014 because the claim service lacked information and that the provider's state billing license number is/was invalid. I could not find where the bills were submitted. Again, all of the EOB's are attached and there is not any for a 4/1/14 and 6/1/14 date of service.

It is the Carrier's position that the \$197.18 is not owed to the requestor, Louis F. Puig for the dates of service, 4/1/2014 and 6/3/2014."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2014 & June 3, 2014	Evaluation & Management, established patient (99213) & Work Status Report (99080)	\$197.18	\$0.00

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 defines the required elements for medical bills submitted by health care providers.
3. 28 Texas Administrative Code §133.502 defines the supplemental data elements required for medical bills submitted electronically by health care providers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Submitted documentation finds no Explanation of Benefits for date of service April 1, 2014.

From Explanation of Benefits for date of service June 3, 2014:

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- F252 – The provider's State Billing License Number is Invalid or was not received pursuant to Texas Rule 133.10.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for date of service April 1, 2014?
2. Is the insurance carrier's reason for denial of payment supported?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

Date of service April 1, 2014 is included in this dispute. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 13, 2015. This date is later than one year after this disputed date of service. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for this date of service.

2. The insurance carrier denied disputed date of service June 3, 2014 with claim adjustment reason code F252 – "The provider's State Billing License Number is Invalid or was not received pursuant to Texas Rule 133.10." If the claim was submitted electronically, the relevant rule is 28 Texas Administrative Code §133.502 (a), which requires that

In addition to the data requirements and standards adopted under §133.500 (a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional/hospital, and dental electronic medical bills submitted before January 1, 2012 must contain:

- (5) the rendering health care provider's state provider license number;

- (6) the referring health care provider's state provider license number;
- (7) the billing provider's state provider license number, if the billing provider has a state provider license number.

If the claim was ultimately submitted as a paper bill, the relevant rule is 28 Texas Administrative Code §133.10 (f)(1), which states,

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');
- (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');
- (EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX').

Review of the submitted information indicates that the billing for this date of service did not include a state license number for the referring provider, the rendering provider, or the billing provider. Based on the evidence provided, whether the bill was submitted electronically or by paper submission, the insurance carrier's denial reason is supported. Therefore, additional reimbursement cannot 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

	Laurie Garnes	May 28, 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, 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.