



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

NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name

VALLEY FORGE INSURANCE CO

MFDR Tracking Number

M4-16-0884-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

December 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These sessions do not require pre-authorization and were necessary to help the client. Please reprocess the attached claim and supporting documentation for payment."

Amount in Dispute: \$120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "HCP letter of November 30, 2015, continues to reference an incorrect NPI number of 17605577681. The medical records attached to the DWC60 include a HICF which contains a correct referring NPI number but was not forwarded to the Carrier and was not received until the filing of this MDR dispute."

Response Submitted by: Law Office of Brian J Judis, 700 N Pearl Suite 425, Dallas, Tx 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2015	96152	\$120.00	\$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 sets out the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by the health care provider.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3- Request for reconsideration
 - Referring provider's NPI# is invalid. Please resubmit bill with this information included.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

The insurance carrier denied disputed services due to "referring provider's NPI# is invalid. 28 Texas Administrative Code §133.20 (c) requires that "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Review of the submitted medical bills finds that an invalid referring provider's NPI number is listed in box 17b of the CMS Form 1500 (02/12). Additionally, an invalid NPI number for the referring provider is also referenced in the requestor's reconsideration letter.

The division notes that one medical bill with a valid NPI number in box 17a was found in the requestor's documentation. There is no evidence to support that this particular medical bill with a print date of March 9, 2015 was presented to the workers compensation insurance carrier in the manner required by the divisions general medical provisions at 28 Texas Administrative Code Chapter 133, Subchapter B. Because the provider failed to submit this medical bill, the carrier was not given the opportunity to pay, reduce or deny this medical bill.

For the reason stated, the division finds that the workers' compensation insurance carrier's denial reason is supported. For that reason, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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 Manager

January 26, 2016
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.