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
Kent L. Mitchell, M.D.

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-16-1060-01

Carrier's Austin Representative
Box Number 04

MFDR Date Received
December 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this patient is an ESTABLISHED Patient billing code 99213 and ***can be seen by*** (P.A. = Physician Assistant), it is only the NEW Patients that should not be seen by P.A's."

Amount in Dispute: $113.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing reflects Kent Mitchell, MD but documentation reflects both the PA and MD signature. The PA has a NPI# and license # so therefore should bill for their own services."

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 8, 2015	Evaluation & Management, established patient (99213)	$113.86	$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 §133.20 sets out the procedures for submitting a medical bill.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B20 – Service partially/fully furnished by another provider
   - Comments: "Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. NAME ON NOTES g HAGMAN, PA-C."
   - 193 – Original payment decision maintained

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code B20 – "Svc partially/fully furnished by another provider." 28 Texas Administrative Code §133.20(e)(2) requires that a medical bill must be submitted "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 submitted information finds that services were provided at least in part by Glenda Hagman, P.A.-C. The Texas Medical Board provides license number PA04946 for this provider. Review of medical bills provided does not find that this service was billed in the name of the licensed health care provider that provided the health care. The insurance carrier's denial reason is supported. 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	January 22, 2016
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.