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
HCAA Medical Group PA

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-16-1351-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
January 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: January 14, 2016: "The bill attached for DOS 9/29/15 keeps getting denied for payment by Corvel. The charges are for a PT Initial Evaluation that was performed on the same day. Although these appt were on the same day we know that the bills are for separate providers for separate specialties."

Supplemental response: February 2, 2016: "Please find that I have included the bill for (Claimant) with Cindy Kennon information now in 24j. This should now make the claim "clean" and now eligible for payment.

Amount in Dispute: $240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In summary, CorVel maintains that final action for date of service 9/29/15 was rendered in accordance with DWC adopted rules."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2015	97110, G8978, G8979	$240.00	$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
   - 18 – Duplicate claim/service

Issues

1. Did the requestor submit the medical claims in compliance with Division guidelines?
2. 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 1508890609 for Mr. Bryce Olson
   b. Health care provider that signed "Progress / Encounter was Cynthia Kennon LIC #PTA2018420TX

   The Division finds the Carrier's denial is supported as the health care provider (Ms. Kennon) was licensed.

2. The provisions of Rule 133.20 were not met. No additional payment can be recommended. The requestor supplemented their response stating," the claim "clean" and now eligible for payment..." 28 Texas Administrative Code §133.20 (g) states, "Health care providers may correct and resubmit as a **new bill** an incomplete bill that has been returned by the insurance carrier." This claim would have to be submitted to the carrier not as part of request for MFDR.

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

		February , 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, 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**.