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
AMERICAN STATES INSURANCE CO

MFDR Tracking Number
M4-16-2498-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 4/23/15, 4/30/15 and 5/7/15, Licensed Professional Counselor, Andrea Zuflact LPC and Salina Shelton LPCI met with [injured employee]. The NPI is clearly on the claim for the provider which is 1407949324, as well as the billing NPI of 1669565529. The referring NPI is 17605577681. The service the HCP (Nueva Vida Behavioral health), who is contracted with CAN."

Amount in Dispute: $354.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 27, 2016. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 23, 2015 through May 7, 2015	90837 x 3	$354.00	$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:
   - 1 – National Provider Identifier missing
   - 1 – Referring provider's NPI# is invalid. Please resubmit bill with this information

Issues

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

Findings

1. 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 17b was found in the requestor's documentation. There is no evidence to support that this particular medical bill with a print date of April 29, 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.
2. 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

		June 10, 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.