



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

Salvador P. Baylan, M.D.

Respondent Name

Federal Insurance Company

MFDR Tracking Number

M4-16-3053-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

June 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reason the carrier is denying for payment, there was no authorization. However, before we had the injured worker started for physical therapy, it was verbally approved by adjuster - Karen Warznie for 6 visit [sic] with no authorization needed."

Amount in Dispute: \$1540.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "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. Sharon Scott, PT is licensed.

CorVel will maintain the requestor, Salvador P Baylan, MD is entitled to \$0.00 reimbursement for date(s) of service 11/24/15 - 01/19/16 based on failure to accurately submit medical billing data in accordance with division rules set forth for a licensed provider."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 24, 2015 - January 19, 2016, Physical Therapy, \$1540.00, \$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 submitting medical bills.

3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B20 – Svc partially/fully furnished by another provider
  - 197 – Payment adjusted for absence of precert/preauth
  - Bill Comments: “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. PER DOCUMENTATION, SHARON SCOTT, PT IS HCP.
  - Bill Comments: “Per rule 134.600, preauth is required for PT-except for the first 6 visits within the first two weeks of the DOI or a surgical procedure. Your bill does not meet either exception and preauth is required.”
  - 236 – This proc or proc/mod combo not compatible
  - R79 – CCI; Standards of Medical/Surgical Practice

### **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.” Further, 28 Texas Administrative Code §133.10(f)(1) requires the following information be included:

- (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');
- (V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number; ...
- (Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier

Review of the submitted information finds that the health care provider listed in CMS-1500/field 31 is Sharon Scott, L.P.T. The progress notes included in the submitted documentation identify Sharon Scott, L.P.T. as the rendering health care provider. The division finds that Sharon Scott is a licensed physical therapist with the state of Texas, license number 1047975, NPI 1487066262. The state license number and NPI number listed in CMS-1500/field 24j are both registered to Salvador Baylan, M.D. 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 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

August 16, 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.**