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
South Texas Radiology Grp

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-16-3500-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have mailed & faxed in our claim several times. Our claim continues to be returned stating Missing Referring Provider state license #. We submit corrected claims & continue to have our claims returned."

Amount in Dispute: $13.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain the requestor, South Texas Radiology Group is entitled to $0.00 reimbursement for date of service 07/22/15 in the amount of $13.54 based on failure to accurately and timely submit a complete medical bill in accordance with health care provider billing rules set forth under 28 TAC Chapter 133 General Medical Provisions."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2015	73100	$13.54	$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 medical bill submission requirements for health care providers.

3. No explanation of benefits was submitted by either party in this dispute.

Issues

1. Is the requestor's position statement supported?
2. Is the respondent's position statement supported?

Findings

1. The requestor submitted the following, "03/28/2016, Our Request for Reconsideration was denied based on Referring Provider License # not valid." Review of the submitted documentation finds the following:

    - Fax cover with date January 8, 2016 with a CMS 1500 showing the following information: 17a – OB NP611125TX
    - Document from CorVel dated Marcy 22, 2016 with the following message, "License NP61125TX is not valid, please correct and re-submit billing

28 Texas Administrative Code §133.10(i) states in pertinent part,

> In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:
>
> (1) AC for Acupuncturist;
> (2) AM for Ambulance Services;
> (3) AS for Ambulatory Surgery Center;
> (4) AU for Audiologist;
> (5) CN for Clinical Nurse Specialist;
> (6) CP for Clinical Psychologist;
> (7) CR for Certified Registered Nurse Anesthetist;
> (8) CS for Clinical Social Worker;
> (9) DC for Doctor of Chiropractic;
> (10) DM for Durable Medical Equipment Supplier;
> (11) DO for Doctor of Osteopathy;
> (12) DP for Doctor of Podiatric Medicine;
> (13) DS for Dentist;
> (14) IL for Independent Laboratory;
> (15) LP for Licensed Professional Counselor;
> (16) LS for Licensed Surgical Assistant;
> (17) MD for Doctor of Medicine;
> (18) MS for Licensed Master Social Worker;
> (19) MT for Massage Therapist;
> (20) NF for Nurse First Assistant;
> (21) OD for Doctor of Optometry;
> (22) OP for Orthotist/Prosthetist;
> (23) OT for Occupational Therapist;
> (24) PA for Physician Assistant;
> (25) PM for Pain Management Clinic;
> (26) PS for Psychologist;
> (27) PT for Physical Therapist;
> (28) RA for Radiology Facility; or
> (29) RN for Registered Nurse.

As seen above the utilized "NP" was not valid. The requestor's position is not supported.

2. The respondent states in their position, "CorVel will maintain the requestor, South Texas Radiology Group is entitled to $0.00 reimbursement for date of service 07/22/15 in the amount of $13.54 based on failure to accurately and timely submit a complete medical bill in accordance with health care provider billing rules set forth under 28 TAC Chapter 133 General Medical Provisions." The Division reviewed "corrected" claims marked as follows:
   - Exhibit D with date 01/06/16 shows OB NP611125TX
   - Exhibit F with date 03/03/16 shows OB NP611125TX
   - Exhibit H with date 05/05/16 shows OB NP611125TX

The respondent's position is supported as the required elements of box 17A of CMS 1500 were not found.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August , 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, 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 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.