



# 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**

ORTHOTEXAS ORTHOPEDICS & SPORTS MEDICINE

**Respondent Name**

FEDERAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-19-3838-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

April 17, 2019

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Dr. Alex Glogau, MD is listed in box 31 & electronically signed the dictation to support box 31 & electronically signed the dictation to support box 31. See the attached documentation that supports the services provided. Please reprocess claim for payment immediately."

**Amount in Dispute:** \$402.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...Dr. Alexander Glogau, MD is listed in conjunction with Jessica Martin, PA-C. The medical documentation further indicates that office visit and/or procedure was administered by Jessica Martin, PA-C... it was found that... the license was active and in good standing at the time services were, provided... As such, CorVel will maintain the requestor, OrthoTexas Physicians & Surgeons is entitled to \$0.00 reimbursement for date of service 10/25/18..."

**Response Submitted by:** CorVel

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2018	99203, 73564 and A9999	\$402.00	\$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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.
- 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by the health care provider.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - B20 – Svc partially/fully furnished by another provider
  - Note: 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. Jessica Martin PAC performed the services

**Issues**

1. Did the requestor comply with the billing requirements set out in 28 Texas Administrative Code §§133.20 and 133.10?
2. Is the requestor entitled to reimbursement?

**Findings**

1. The carrier asserts it is not liable for the disputed amount of \$402.00 under 28 Texas Administrative Code §133.20(d)(2), and 28 Texas Administrative Code §133.20(e)(2). The carrier indicates in the explanation of benefits (EOB) that “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. Jessica Martin PAC performed the services.”

28 Texas Administrative Code §133.20(d) states that the health care provider that provided the health care shall submit its own bill, unless: (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill

28 Texas Administrative Code §133.20 (e) states that a medical bill must be submitted: (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.

28 Texas Administrative Code §133.10(f) (1) (U) and (V), the **rendering provider’s** information is required to be listed in box 24j, shaded (state license) and un-shaded (NPI) fields. Read together, these provisions only allow for a supervising provider to be listed in 24j if the rendering provider is not licensed.

Review of the CMS 1500’s finds that the healthcare provider identified in box 31 and 24j is Alexander Glogau, M.D. The requestor indicates in their position summary that “Dr. Alex Glogau, MD is listed in box 31 & electronically signed the dictation to support box 31. See the attached documentation that supports the services provided. Please reprocess claim for payment immediately.” Review of the requestors “Office Visit” dated October 25, 2018 states, “The office visit and/or procedure was administered by Jessica Martin, PA-C # PA 10462 under supervising physician Alexander Glogau MD.”

2. The division finds that the bill should have been submitted in the name of the licensed provider who rendered the service in order for the Carrier to be liable for the amount in dispute. For that reason, reimbursement is not recommended for the disputed services rendered on October 25, 2018.

**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**

		May 15, 2019
Signature	Medical Fee Dispute Resolution Manager	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.**