



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
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512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DALLAS TESTING, INC

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-20-2888-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

AUGUST 10, 2020

REQUESTOR'S POSITION SUMMARY

"This provider is an authorized treater in workers' compensation. The treating doctor referring the patient to our provider to have the PHYSICAL PERFORMANCE EVALUATION. All necessary and supporting documentation is included with this reconsideration to properly justify/support the administered treatment still needing to be paid."

Disputed Amount: \$472.64

RESPONDENT'S POSITION SUMMARY

"Based on medical documentation submitted by Dallas Testing, Inc for date of service 10/10/19, the functional capacity evaluation (FCE) was administered by Jeff Hicken, DC. Upon verification of the state licensure status of the documented rendering provider on the Texas Board of Chiropractor Examiners website (Exhibit A), it was, found that license number DC [REDACTED] was issued to Jeff Hicken on [REDACTED]. However, the license was in non-renewable status at the time services were, rendered with an expiration date of 09/01/18. Anthony Esquibel, DC is listed in box 31 with licensing information in 24j of the CMS-1500. However, there has been no documentation provided by Dallas Testing Inc. indicating that Anthony Esquibel, DC was providing direct supervision of an unlicensed individual who provided the heal care on the date in question. As such, CorVel will maintain the requestor, Dallas Testing, Inc. is entitled to \$0.00 reimbursement for date of service 10/10/19, CPT Code 97750 (GP) in the amount of \$472.64 based on failure to accurately submit medical billing data in accordance with division rules set forth for a licensed provider."

Response Submitted By: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2019	CPT Code 97750-GP (X8) Physical Performance Evaluation	\$472.64	\$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10, effective April 1, 2014, sets out the health care providers billing procedures for required billing forms and formats.
3. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures for medical bill submission.
4. 28 TAC §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
5. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
 - B20-Srvc partially/fully furnished by another provider.
 - GP-Service delivered under OP PT care plan.
 - W3-Appeal/Reconsideration.

Issue

Is the requestor entitled to reimbursement for CPT code 97750-GP (X8) rendered on October 10, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$472.64 for CPT code 97750-GP (X8) rendered on October 10, 2019.
2. The respondent denied reimbursement for CPT code 97750-GP based upon, "B20-Srvc partially/fully furnished by another provider."
3. To determine if the requestor is entitled to reimbursement, the DWC reviewed the following rules and Medicare Policies:
 - 28 TAC §133.10 (f)(1)(Z) states,

All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (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."
 - 28 TAC §133.20(d)(2) requires, "The health care provider that provided the health care shall submit its own bill, unless: 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 TAC §133.20(e)(2) requires, "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 TAC §134.203(a)(5) states, "Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

- Medicare General Information, Eligibility, and Entitlement, Chapter 5-Definitions, §10.3-Under Arrangements, effective September 12, 2005, states in part,

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services. The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress NOTES relating to all services received, and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders.

- Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, §230.6-Therapy Services Furnished Under Arrangements with Providers and Clinics, A- General states in part,

A provider may have others furnish outpatient therapy (physical therapy, occupational therapy, or speech-language pathology) services through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. However, it is not intended that the provider merely serve as a billing mechanism for the other party. For such services to be covered the provider must assume professional responsibility for the services. The provider's professional supervision over the services requires application of many of the same controls that are applied to services furnished by salaried employees. The provider must: Maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, orders, and progress notes relating to all services received.

- Medicare Claims Processing Manual, Chapter 26-Completing and Processing Form CMS-1500 Data Set, 10.4-Items 14-33-Provider of Service or Supplier Information, effective October 7, 2019 states,

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed. In the case of a service that is provided incident to the service of a physician or nonphysician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

4. The DWC reviewed the submitted documentation from both parties and finds:

- Dr. Jeff Hicken performed and signed the physical performance evaluation rendered on October 10, 2019.
- Per the Texas Board of Chiropractic Examiners, Jeffrey Hicken's license was in non-renewable status with expiration date of September 1, 2018.
- Per 28 TAC §133.10 (f)(1)(Z) and Medicare Policies, the rendering or supervising provider is listed in box 31 of the CMS-1500. Dr. Anthony Esquibel's name is in box 31 of CMS-1500.
- Per 28 TAC §133.20(d)(2) and (e)(2), Dr. Esquibel may submit the bill if he provided direct supervision of an unlicensed individual. The submitted medical report does not support that Dr. Esquibel provided direct supervision to Dr. Hicken.
- The submitted medical report does not support an arrangement between Dr. Esquibel and

Dr. Hicken that meets Medicare "Under Arrangement" Policies, allowing Dr. Esquibel to bill for services provided by Dr. Hicken.

- The submitted medical report does not support Dr. Esquibel maintained the clinical records and provided direct supervision of an unlicensed individual.
- The respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	9/11/2020
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.