TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UT Health East Texas Rehab

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-2995-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 25, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This appeal was denied based on the diagnosis code. The diagnosis code cannot be changed."

Amount in Dispute: $1,193.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The physical therapist in Box 77 as the operating provider is invalid as this service is not for surgical services and this provider is not licensed to perform surgical services. The correct location for the physical therapist credentials is in Box 76."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3 – 31, 2020	Outpatient Physical Therapy	$1,193.82	$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 §134.203 sets out the guidelines for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - B20 – Payment adjusted because procedure/service was partially or fully furnished by another provider

- B22 – This payment is adjusted based on the diagnosis
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

Is the insurance carrier's denial of payment supported?

Findings

The requestor is seeking reimbursement of $1,193.82 for outpatient physical therapy services rendered in March 2020. The insurance carrier denied based on lacking information and service partially or fully furnished by another provider. The position statement submitted by the insurance carrier states, "The physical therapist in Box 77 as the operating provider is invalid… The correct location for the physical therapist credential is in Box 76."

28 TAC §133.10 (f) (2) (PP) state in pertinent parts, The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:

> (PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill, the billing provider shall report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

Review of the submitted medical bill found at www.npiregistry.cms.hhs.gov in box 77 is 1841672474 registered to Christopher Davis, physical therapist.

The submitted medical bill was not for a surgical procedure. Based on the provision of 28 TAC §133.10 (2)(PP) the information submitted on the medical bill in dispute was invalid. The insurance carrier's denial is supported. No payment is recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 9, 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 Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.