Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JASON RICHARD BAILEY, MD

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-22-2325-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
June 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 11, 2021	26525, 14040, 26445, 20680, 76000 and 64450	$19,576.80	$0.00
	Total	$19,576.80	$0.00

Requestor's Position

"• Claim denied for invalid/missing billing provider license number.
- We have added Dr. Ashford's provider license number to box 33B of the claim."

Amount in Dispute: $19,576.80

Respondent's Position

"The review determined that the provider is not due additional money. Attached is a copy of the EOR that includes bill review's explanation."

Response Submitted by: ESIS

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10 sets out the required billing forms/formats.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- DCN – Bill denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review. Bill denied; invalid/missing referring provider license number. Please re-submit with appropriate license number.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Is the Insurance Carrier's denial reason supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The Requestor seeks reimbursement in the amount of $19,576.80 for CPT Codes 26525, 14040, 26445, 20680, 76000 and 64450 rendered on November 11, 2021.

   The insurance carrier denied the disputed service with denial reason codes indicated above.

   28 TAC §133.10 states, "(K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX')..."

   28 TAC §133.10 states, "(L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number..."

   The DWC finds that the requestor's medical bills (CMS-1500s) submitted with the DWC060 contains the name of a referring doctor in box 17 on both copies of medical bills, however, review of box 17a does not contain the state license number of the referring doctor listed in box17 on both medical bills submitted for review.

The DWC finds that the insurance carrier's denial reasons are supported. As a result, the requestor is not eligible for reimbursement for the services in dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement is not due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is not entitled to additional reimbursement for the disputed services.

Authorized Signature

______________________	______________________	August 10, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.