



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Perez, Brandon Aaron

**Respondent Name**

Ace American Insurance Co

**MFDR Tracking Number**

M4-23-2884-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

July 14, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 2, 2023	29827	\$14188.00	\$0.00
February 2, 2023	29828	\$13428.00	\$0.00
February 2, 2023	29826	\$6974.00	\$0.00
February 2, 2023	C1713 X2	\$2534.00	\$0.00
February 2, 2023	C1713	\$2601.60	\$0.00
<b>Total</b>		<b>\$39,726.00</b>	<b>\$0.00</b>

### Requestor's Position

"We have tried to get this claim appealed with the correct provider license number by including it on the HCFA and sending in a copy of our license in a reconsideration. We spoke with representative Jen ref #JS004564 on 5/22 and were told that we needed the NPI on box 31, 33b and 24J. We corrected and faxed the number that she provided."

**Amount in Dispute:** \$39,726.00

### Respondent's Position

"ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of \$0. Original bill was denied for

both Facility License and Referring Provide [sic] License. Although the Facility license was provided we never received the Referring providers license in box 17A.”

**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 billing and coding guidelines for ambulatory surgical facility billing.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – TDI Level 1 Appeal means a request for reconsideration 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

### Issues

1. Is the insurance carrier’s denial supported?

### Findings

1. The requestor is seeking reimbursement of ambulatory surgical services rendered in February of 2023. The insurance carrier denied the claim originally as claim lacking information and again at reconsideration for the same reason.

DWC Rule 133.10 (f)1)(A-V) states in pertinent parts,

(f) 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:

(A) patient's Social Security Number (CMS-1500/field 1a) is required;

(B) patient's name (CMS-1500/field 2) is required;

(C) patient's date of birth and gender (CMS-1500/field 3) is required;

(D) employer's name (CMS-1500/field 4) is required;

(E) patient's address (CMS-1500/field 5) is required;

(F) patient's relationship to subscriber (CMS-1500, field 6) is required;

(G) employer's address (CMS-1500, field 7) is required;

(H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known, the billing provider shall leave the field blank if the workers' compensation claim number is not known by the billing provider;

(I) date of injury and "431" qualifier (CMS-1500, field 14) are required;

(J) name of referring provider or other source is required when another health care provider referred the patient for the services; No qualifier indicating the role of the provider is required (CMS-1500, field 17);

**(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 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');**

**(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;**

(M) diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code and the applicable ICD indicator must be present;

(N) prior authorization number (CMS-1500/field 23) is required when preauthorization, concurrent review or voluntary certification was approved and the insurance carrier provided an approval number to the requesting health care provider;

(O) date(s) of service (CMS-1500, field 24A) is required;

- (P) place of service code(s) (CMS-1500, field 24B) is required;
- (Q) procedure/modifier code (CMS-1500, field 24D) is required;
- (R) diagnosis pointer (CMS-1500, field 24E) is required;
- (S) charges for each listed service (CMS-1500, field 24F) is required;
- (T) number of days or units (CMS-1500, field 24G) is required;
- (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');**
- (V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;**

The state license of Brandon Aaron Perez, MD found at <https://profile.tmb.state.tus.us>, was not in box 17a in the format required on the medical bills submitted with this medical fee dispute.

Based on the required elements of the medical bill not being complete, the DWC finds the insurance carrier's denial is supported and no payment is recommended.

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.

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

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

November 30, 2023  
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](http://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. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

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\(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).