TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Jay Chavda, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-24-1640-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 23, 2023, through February 28, 2024	Physical Therapy services	$44,130.00	$0.00
	Total	$44,130.00	$0.00

Requestor's Position

"Claim was denied by the Texas mutual due to rendering provider must be billed for service and it should be updated on the box 24 J and box 31, Also it require the license type tax ID and NPI on the both the boxes, So we added the license number on box 24J and 31 and this claim was performed under the supervision of Dr. Jay Chavda for that we added the 'CQ modifier' (Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant), So we are providing the information asked by Texas mutual. Please review the bill and process for the payment."

Amount in Dispute: $44,130.00

Respondents' Position

"The bills were billed by Dr Jay Chavada, an ear nose and throat specialist. Included in the documentation from the DWC-60 packet services were rendered by a licensed physical therapist. During the audit of these bills, it was determined that a licensed physical therapist rendered the service, therefore the bill was denied per rule 133.20(d). Please reference the DWC-60 packet where the licensed physical therapist has signed off on the documentation and then the co-signature is that of the referring medical provider. See DWC-60 packet pages: 10, 13, 18, 21, 26, 29, 34, 37, 42, 45, 50, 53, 57, 60, 66, 69, 74, 79, 85, 89, 95, 100, 106, 111, 117, 122, 128, 134, 140, 145, 150, 157, 160, and 165. The carrier audited and denied the bills per rule 133.20(d) The health

care provider that, provided the health care shall submit its own bill… Our position is that no payment is due."

Response submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. 28 TAC §133.250 sets out procedure for reconsideration of a medical bill.
5. 28 TAC §133.20 sets out the guidelines for medical bill submission by Health Care Provider.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following adjustment reason codes:

- A19 – Rendering provider must bill for services. Update box 24J and box 31 of the CMS-1500 to reflect the rendering of providers information. Please correct CMS-1500 and submit a request for reconsideration.
- A19 – DWC Rules 133.10, 133.20 & clean claim guide require license type, tax ID, NPI, state jurisdiction of licensed HCP who rendered services.
- CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.

Issues

1. Is the requestor eligible for medical fee dispute resolution for dates of service, January 18, 2024, through February 28, 2024?
2. Did the requestor seek reconsideration for disputed services rendered on September 11, 2023, December 27, 2023, and January 3, 2024?
3. Is insurance carrier denial reason supported for dates of service June 23, 2023, through September 6, 2023, and October 17, 2023, through December 20, 2023?
4. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to the non-payment of physical therapy services rendered on January 18, 2024, through February 28, 2024.

   Pursuant to 28 TAC §133.307, the requestor is required to submit along with the DWC060 request, a copy of all medical bills related to the dispute, each explanation of benefits or e-remittance related to the dispute, and a copy of all applicable medical records related to the dates of service in dispute.

   28 TAC §133.307 (c)(2)(J)(K)(M) states in pertinent part, "Requests for MFDR must be legible and filed in the form and manner prescribed by the division…

   (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include…

   > (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills);
   >
   > (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB...
   >
   > (M) a copy of all applicable medical records related to the dates of service in dispute."

   The DWC determines that the following service dates are not eligible for medical fee dispute resolution: January 18, 2024, January 30, 2024, February 13, 2024, February 20, 2024, and February 28, 2024. Consequently, this review will not consider the services provided on these dates.

   The DWC finds that dates of service June 23, 2023, through January 3, 2024, are reviewed pursuant to the applicable rules and guidelines.

2. A review of the medical records for services rendered on September 11, 2023, December 27, 2023, and January 3, 2024, revealed that the requestor did not include documentation to support that reconsideration was sought prior the filing of the medical fee dispute. The health care provider is permitted to file for medical fee dispute resolution only after it has filed for reconsideration, per 28 TAC §133.250. The healthcare provider has 10 months from the date of service to request a reconsideration.

28 TAC §133.250 (g) states that the insurance carrier's deadline to take final action and issue an explanation of benefits is 30 days from the date of receipt of the request for reconsideration. If after 35 days, there is no indication of final action from the insurance carrier, the health care provider may then file for medical fee dispute resolution.

If the healthcare provider has not received an explanation of benefits from the insurance carrier, and if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

Documentation submitted by the requestor does not support that a reconsideration was sought prior to the filing of the MDR therefore, services rendered September 11, 2023, December 27, 2023, and January 3, 2024, are not eligible for review.

3. The requestor seeks reimbursement for physical therapy services rendered on June 23, 2023, through September 6, 2023, and October 17, 2023, through December 20, 2023. To determine if the requestor is entitled to reimbursement, the DWC considered the following division rules and Medicare policies.

   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 other 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 the 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 non-physician 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.

Runtai Xu, PT, Clancy Bryce Nelson, PT, and Kassidy Shantel Rieger, PT performed and signed the physical therapy services provided June 23, 2023, through September 6, 2023, and October 17, 2023, through December 20, 2023.

- Per the Texas Board of Physical Therapy Examiners, Runtai Xu, PT, Clancy Bryce Nelson, PT, and Kassidy Shantel Rieger, PT, are licensed physical therapists.
- Per the Texas Medical Board, Jay Chavda, MD, is a licensed physician.
- 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. Jay Chavda, name is in box 31 of CMS-1500.
- Per 28 TAC §133.20(d)(2) and (e)(2), Dr. Jay Chavda, may submit the bill if he provided direct supervision of an unlicensed individual. The submitted medical report does not support that Dr. Jay Chavda provided direct supervision to Runtai Xu, PT, Clancy Bryce

Nelson, PT, and Kassidy Shantel Rieger, PT.

- The submitted medical report does not support an arrangement between Dr. Chavda and Runtai Xu, PT, Clancy Bryce Nelson, PT, and Kassidy Shantel Rieger, PT that meets Medicare "Under Arrangement" Policies, allowing Dr. Chavda to bill for services provided by Runtai Xu, PT, Clancy Bryce Nelson, PT, and Kassidy Shantel Rieger, PT.
- The medical report submitted does not support Dr. Chavda, who maintained the clinical records and provided direct supervision of an unlicensed individual.

The DWC finds that for the reasons indicated above, the requestor is not entitled to reimbursement for the services rendered on June 23, 2023, through February 28, 2024.

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 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	January 31, 2025 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. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email 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 electronico CompConnection@tdi.texas.gov.