TDI 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
Joel Joselevitz, M.D.

Respondent Name
American Zurich Insurance Co.

MFDR Tracking Number
M4-24-2416-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 1, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 5, 2023	99205	$433.11	$0.00
July 5, 2023	95886	$384.22	$0.00
July 5, 2023	95911	$416.40	$0.00
	Total	$1,233.73	$0.00

Requestor's Position

"The EMG/NCV was incorrectly denied because it was requested by the Designated Doctor."

Amount in Dispute: $1,233.73

Respondent's Position

"...the medical bill did not include any information at box number 21 which is the diagnosis code. The Texas Claim And Electronic Medical Billing And Payment Companion Guides provide that box number 21 is a required box. Until it is completed, the provider's medical bill is an incomplete medical bill."

Response Submitted by: Flahive, Ogden & Latson

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) §133.2 provides definitions for medical billing and processing rules.
2. 28 TAC §133.10 sets out the procedures for required billing forms/formats.
3. 28 TAC §133.200 sets out the procedure for medical bill processing/audit by insurance carrier.
4. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the insurance carrier return the disputed medical bill in accordance with 28 TAC §133.200?
2. Did the requestor submit a complete medical bill for the services in dispute and is the requestor entitled to reimbursement for the disputed services rendered on July 5, 2023?

Findings

1. Per the submitted documentation, the insurance carrier returned the original medical bill in question based on missing diagnosis code in field 21 of the medical billing form.

   28 TAC §133.2(4) defines a "complete medical bill" as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter …, or as specified for electronic medical bills in §133.500 of this chapter…"

   28 TAC §133.200(a)(2) (A-B) states in pertinent part, "Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier must: (A) complete the bill by adding missing information already known to the insurance carrier, except for the following: (i) dates of service; (ii) procedure or modifier codes; (iii) number of units; and (iv) charges; **OR** (B) return the bill to the sender, in accordance with subsection (c) of this section." 28 TAC §133.200 further states that "(b) An insurance carrier must not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier must include a document identifying the reasons for returning the bill. The reasons related to the procedure or modifier codes must identify the reasons by line item. (c) The proper return of an incomplete medical bill in accordance with this section fulfills the

insurance carrier's obligations with regard to the incomplete bill."

28 TAC §133.10(f)(1)(M) requires that at least one diagnosis code be present in field 21 of the CMS-1500 billing form. A review of the medical bills submitted finds that field 21 of the medical bills were blank therefore no diagnosis code was present on the CMS-1500 medical billing form as required by 28 TAC §133.10(f)(1)(M).

A review of the submitted evidence finds that the insurance carrier returned the medical bill due to lack of a diagnosis code, with notification identifying the reasons for returning the bill. Therefore, DWC finds that the insurance carrier returned the disputed medical bill in accordance with 28 TAC §133.200.

2. The requestor is seeking reimbursement in the amount of $1,233.73 for designated doctor referred services rendered on July 5, 2023.

   In its review of the submitted documentation, DWC found no evidence to support that the requestor ever submitted a complete medical bill to the insurance carrier in accordance with 28 TAC §133.10(f), for the services in dispute. Therefore, DWC finds that the requestor is not entitled to reimbursement for the services rendered on July 5, 2023.

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 requestor 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

		July 26, 2024
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. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option three, 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 tres o correo electronico CompConnection@tdi.texas.gov.