



# 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 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

John Michael Roberson DDS

**Respondent Name**

Chubb Indemnity Co

**MFDR Tracking Number**

M4-13-0990-01

**Carrier's Austin Representative**

Box Number 17

**MFDR Date Received**

December 17, 2012

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Enclosed please find copies of worker's compensation papers from a case I have finished. They state I must accept approximately one-third of my normal fee as payment in full. Please inform me if this correct. If it is, I will never more treat any worker's compensation case. I might as well give my services away. I do sometimes, but refuse to be forced to."

**Amount in Dispute:** \$2, 967.98

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Enclosed please find an amended EOB which allowed payment of all billed services... No additional reimbursement is allowed."

**Response Submitted by:** Downs ♦ Stanford, P.C.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25 – June 20, 2012	Dental Services	\$2,967.98	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.303 sets out the reimbursement guidelines for dental services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W1 – Workers Compensation State Fee Schedule Adjustment
  - W3 – Additional reimbursement made on reconsideration
  - 193 – Original payment decision maintained

**Issues**

- What is the applicable rule that relates to reimbursement of disputed services?

2. Is the requestor entitled to reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.303(c) "To determine the maximum allowable reimbursements (MARs), the following apply: (1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%." Calculations of Maximum Allowable Reimbursement (MAR) will be as follows;

Date of Service	Submitted Code	Submitted Charge	MAR
			Texas Medicaid Dental Fee Schedule Amount x 200%
April 25, 2012	D0140	\$86.00	\$18.78 X 200% = \$37.56
April 27, 2012	D0220	\$36.00	\$12.56 X 200% = \$25.12
April 27, 2012	D0230	\$30.00	\$11.51 X 200% = \$23.00
April 27, 2012	D0230	\$30.00	\$11.51 X 200% = \$23.00
April 27, 2012	D0230	\$30.00	\$11.51 X 200% = \$23.00
June 20, 2012	D7210	\$355.00	\$100.75 X 200% = \$201.50
June 20, 2012	D6240	\$1,395.00	\$258.72 X 200% = \$517.44
June 20, 2012	D6720	\$1,201.00	\$258.72 X 200% = \$517.44
June 20, 2012	D6720	\$1,201.00	\$258.72 X 200% = \$517.44
	Total	\$4,364.00	\$1,885.50

2. The MAR for the services in dispute is \$1,885.50. The carrier paid \$1,924.02. No additional payment can be recommended. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

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

December , 2014  
\_\_\_\_\_  
Date

**YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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