



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Richard Baker DDS

Respondent Name

Wal Mart Associates Inc

MFDR Tracking Number

M4-13-0394-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

October 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Richard Y Baker is a general dentist practicing for over 43 years in Texas and is fully licensed in the state of Texas to perform all dental treatment."

Amount in Dispute: \$1,162.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The health care provider has not submitted a request for reconsideration in accordance with TDI-DWC Rule 133,250(h); therefore, the request is not subject to medical fee dispute resolution."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 29, 2011	70320, 99282		
December 7, 2011	99070, 41899	\$1,162.00	\$150.04
April 18, 2012	41899		

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.303 sets out the reimbursement guidelines for dental services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 8 – The procedure code is inconsistent with the provider type/specialty
 - 238 – The billed service falls outside the provider's scope of specialty
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - 243 – The charge for this procedure was not paid since the value of this procedure is include/bundled within the value of another procedure performed.

Issues

1. Was the provider eligible to provide disputed services?
2. What is the applicable rule that relates to reimbursement of disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as 238 – “The billed service falls outside the provider’s scope of specialty and 8 – “The procedure code is inconsistent with the provider type/specialty.” Review of the National Plan & Provider Enumeration System (NPPI) the providers’ taxonomy is 1223G0001X – Dentist-General Practice and License number 8640 in the state of Texas. The carrier’s denial is not supported.
2. 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%
November 29, 2011	70320	\$118.00	\$34.75 x 200% = \$69.50
November 29, 2011	99282	\$76.00	\$40.27 x 200% = \$80.54
December 7, 2011	99070	\$635.00	Not payable/bundled
December 7, 2011	41899	\$238.00	\$0.00 per Texas Medicaid Dental Fee Schedule
April 18, 2012	41899	\$75.00	\$0.00 per Texas Medicaid Dental Fee Schedule
	Total	\$1,162.00	\$150.04

3. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for disputed codes 70320 and 99281-2. As a result, the amount ordered is \$150.04.

The December 7, 2011 charge submitted with CPT code 99070 was denied as 243 – “The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.” This code has a status “B” indicator and is considered bundled. The carrier’s decision is supported.

The December 7, 2011 and April 18, 2012 charges submitted with CPT code 41899 were denied with reasons the Division has found are not supported. 28 Texas Administrative Code §134.303 (c)(2) states, “For products and services for which the Texas Medicaid Dental Fee Schedule does not establish a value, **the carrier shall assign a relative value**, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and value assigned for services involving similar work and resource commitments.” The Carrier failed to assign a relative value and is hereby ordered to assign a relative value and reprocess these line items per Division guidelines.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order and to reprocess the disputed services for dates of service December 7, 2011 and April 18, 2012 after assigning a relative value to the CPT submitted code 41899.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February , 2015
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.