



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GARY L GEACCONI DDS

Respondent Name

TPCIGA FOR LEGION INSURANCE CO

MFDR Tracking Number

M4-15-2200-01

Carrier's Austin Representative

Box Number 50

MFDR Date Received

March 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Property and casualty Insurance Guaranty Association (TPCIGA) has refused to pay Dr. Gary L. Geaconne DDS dental services provided to [injured employee] following the letter of approval for treatment... A pre-authorization for treatment was approved on 08/08/2014 and services were provided on 08/13/2014. We received a certified letter after services were completed denying payment after services were approved. We received a check for the services Dr. Geaconne provided. Then we received a phone call from (TPCIGA) denying the payment that the check had a stop payment on it. This check wasn't cashed... The insurance company gave the approval to do the work, which we did in good faith that (TPCIGA) would honor their approval of treatment."

Amount in Dispute: \$14,845.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...for date of service June 16, 2014, this is the first time this bill has been submitted to TPCIGA for review. TPCIGA is currently reviewing it for timely filing, Dr. Geaconne not being the treating physician, nor a referral physician at that time, and will also be reviewed per the PLN-11 dispute. As for date of service August 13, 2015, the PLN-11 was already on file with DWC and had been sent by verifiable means to Dr. Geaconne. Since the dates of service in question have been disputed per the PLN-11 on file, a Medical Fee Dispute Resolution is not the proper avenue for this dispute resolution. The proper avenue would be a Benefit Review Conference (BRC) since it has now become an extent of injury issue."

Response Submitted by: Texas Property and Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include June 16, 2014 and August 13, 2014, with a Total row at the bottom.

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 §133.305 sets out the MDR- General Guidelines.
3. 28 Texas Administrative Code §134.303 sets out the 2005 Dental Fee Guideline.
4. 28 Texas Administrative Code §133.2 sets out the Definitions for General Rules for Medical Billing and Processing.
5. 28 Texas Administrative Code §133.230 sets out the Insurance Carrier Audit of a Medical Bill.
6. 28 Texas Administrative Code §133.240 sets out the Medical Payments and Denials.
7. 28 Texas Administrative Code §133.250 sets out the Reconsideration for Payment of Medical Bills.
8. 28 Texas Administrative Code §134.1 sets out the Medical Reimbursement.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 219-Based on extent of injury.
 - B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
 - P12 – Workers Compensation jurisdictional fee schedule adjustment.
 - Charges exceed Fee Schedule allowance

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307 for date of service June 16, 2014?
2. Is the disputed service rendered on June 16, 2014 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the insurance audit the disputed charges rendered on August 13, 2014 in accordance with 28 Texas Administrative Code 133.240 and 133.250?
4. Is the requestor entitled to reimbursement for the dental services?

Findings

1. The requestor seeks resolution of dental services rendered on June 16, 2014, denied/reduced by the insurance carrier with denial reason code “219-Based on extent of injury” and B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.”

28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

28 Texas Administrative Code §133.307(f)(3)(C), requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to 28 Texas Administrative Code §124.2 of this title. The appropriate dispute process to resolve issues of extent of injury requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. The division will dismiss date of service June 16, 2014 until the dispute has been resolved by a final decision, inclusive of all appeals.

The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent-of-injury issue are attached.

2. 28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307. For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning extent-of-injury for the injured employee's workers' compensation claim has been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for date of service June 16, 2014. As a result, no amount is ordered for this date of service.

3. The requestor seeks resolution for dental services rendered on August 13, 2014. The insurance carrier issued payment in the amount of \$9,739.00, for date of service, August 13, 2014 on October 10, 2014, control number 1635491. The insurance carrier issued a stop payment on the check and re-issued another EOB a few days later, on October 24, 2014, control number 1639684.

Per 28 Texas Administrative Code §133.240, "(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

28 Texas Administrative Code §133.2 *Definitions* states in pertinent part, "(6) Final action on a medical bill- (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or (B) denying a charge on the medical bill."

28 Texas Administrative Code §134.1 (e) states, "Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with: (1) the Division's fee guidelines; (2) a negotiated contract; or (3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section."

28 Texas Administrative Code §133.230 states, "(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action."

The Division finds that the insurance carrier has taken final action on the initial medical bills in accordance with 28 Texas Administrative Code §134.1 (e) (1), by issuing reimbursement for the health care per the Division's fee guidelines. As a result, the stop payment initiated by the insurance carrier a few days after the original audit of the medical bill is not supported per 28 Texas Administrative Code §133.230(a). The Division finds that the insurance carrier's defenses raised after the "final action" of a medical bill review has taken place is not supported and therefore, will not be addressed in this decision. The Division will therefore, only consider the defenses raised by the insurance carrier on the EOB's that constitute "final action" for service date August 13, 2014.

4. The Requestor seeks reimbursement for preauthorized dental services rendered on August 13, 2014. Reimbursement is determined per 28 Texas Administrative Code §134.303, applicable to professional dental services provided on or after June 15, 2005. The disputed services were reduced with denial reason code "P12 – Workers Compensation jurisdictional fee schedule adjustment and Charges exceed Fee Schedule allowance."

28 Texas Administrative Code §134.303 (b) states, "For coding, billing, reporting, and reimbursement of dental treatments and services, Texas Workers' Compensation system participants shall apply the Texas Medicaid Dental Fee Schedule in effect on the date a service is provided with any additions or exceptions in this section."

28 Texas Administrative Code §134.303 (c) states, "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%. (2) 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 values assigned for services involving similar work and resource commitments."

28 Texas Administrative Code §134.303 (c) (e) states, "In all cases, reimbursement shall be the lesser of the: (1) MAR amount; (2) health care provider's usual and customary charge; or (3) workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

Review of the ADA Dental Claim Form, box 38 identifies the place of treatment as the provider's office. The MAR amount for dental services provided in a non-facility setting is as follows:

- The Texas Medicaid Dental Fee Schedule for dental code D6750, tooth number 3 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth number 4 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6750, tooth number 6 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D2750, tooth number 7 is $528 \times 200\% = \text{MAR } \$1,056.00$. The requestor seeks $\$925.00$ the lesser of is the health care provider's usual and customary charge, as a result the requestor is entitled to reimbursement in the amount of $\$925.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D2750, tooth number 8 is $528 \times 200\% = \text{MAR } \$1,056.00$. The requestor seeks $\$925.00$ the lesser of is the health care provider's usual and customary charge, as a result the requestor is entitled to reimbursement in the amount of $\$925.00$.
- The Texas Medicaid Dental Fee Schedule amount for dental code D2750, tooth number 9 is $528 \times 200\% = \text{MAR } \$1,056.00$. The requestor seeks $\$925.00$ the lesser of is the health care provider's usual and customary charge, as a result the requestor is entitled to reimbursement in the amount of $\$925.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D2750, tooth number 10 is $528 \times 200\% = \text{MAR } \$1,056.00$. The requestor seeks $\$925.00$ the lesser of is the health care provider's usual and customary charge, as a result the requestor is entitled to reimbursement in the amount of $\$925.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6750, tooth number 11 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth system JP, tooth number 12 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth system JP, tooth number 13 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6240, tooth system JP, tooth number 14 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D6750, tooth system JP, tooth number 15 is $\$264 \times 200\% = \text{MAR } \528.00 . The requestor seeks $\$925.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$528.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D2850, tooth system JP, tooth number 21 is $\$36.58 \times 200\% = \text{MAR } \73.16 . The requestor seeks $\$250.00$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$73.16$.
- The Texas Medicaid Dental Fee Schedule for dental code D2750, tooth system JP, tooth number 21 is $528 \times 200\% = \text{MAR } \$1,056.00$. The requestor seeks $\$925.00$ the lesser of is the health care provider's usual and customary charge, as a result the requestor is entitled to reimbursement in the amount of $\$925.00$.
- The Texas Medicaid Dental Fee Schedule for dental code D5214, tooth system JP is $\$400 \times 200\% = \text{MAR } \800.00 . The requestor seeks $\$1,800$ the lesser of is the MAR, as a result the requestor is entitled to reimbursement in the amount of $\$800.00$.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$9,722.16.

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 \$9,722.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 3, 2015 Date
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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.