



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Derek Winegar DDS

Respondent Name

Sentry Casualty Co

MFDR Tracking Number

M4-15-2705-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "First and Foremost, after doing some research on the dental providers in this area I found that majority of the codes were paid by Sentry at or below the 20th percentile of dentists in this area. Although we are not the least expensive office in the area we are certainly not the most expensive and believe that our fees are fair. Secondly, when we agreed to see this patient, were never told that we would be payed based on an adjusted fee schedule. If this is the way that worker's comp works... it is only fair that this be communicated prior to treatment being given."

Amount in Dispute: \$872.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill is priced correct according to the fee schedule. The provider is disputing that he was not notified this as a WC claim, in the 04/21/15 letter it does say they were told the accident happened at work."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 16, 2014, D0140, D0363, D7210, D9230, D5820, D9950, \$872.94, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203 sets out the fee guidelines for dental services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- P12 – Workers compensation jurisdictional fee schedule adjustment
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
 - P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. What is the rule applicable to the appropriate fee guidelines?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (c) states in pertinent part, “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%.” The maximum allowable reimbursement is calculated as follows;

Date of service	Submitted Code	Submitted Charge	Medicaid Fee	Total allowable
December 16, 2014	D0140	\$79.00	\$19.16	19.32 x 200% = \$38.32
December 16, 2014	D0363	\$610.00	\$231.00	231.00 x 200% = \$462.00
December 16, 2014	D7210	\$293.00	\$102.81	102.81 x 200% = \$205.62
December 16, 2014	D7953	\$432.00	\$250.00	250 x 200% = \$500.00
December 16, 2014	D9230	\$77.00	\$28.38	28.38 x 200% = \$56.76
December 16, 2014	D5820	\$764.00	\$162.50	162.50 x 200% = \$325.00
December 16, 2014	D9950	\$387.00	\$56.25	56.25 x 200% = \$112.50
			Total	\$1,700.20

2. The total recommended payment for the services in dispute is \$1,700.20. This amount less the amount previously paid by the insurance carrier of \$1,769.06 leaves an amount due to the requestor of \$0.00. No additional payment is recommended.

Conclusion

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

Date

May , 2015

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, 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 MFDR 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.