



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

CITY CREEK DENTAL
C/O DEREK WINEGAR DDS

Respondent Name

SENTRY CASUALTY CO

MFDR Tracking Number

M4-16-0543-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Due to the fee schedule forced upon providers we are not able to afford seeing these patients in need which is very sad. We hope that you will please reconsider the payment for the treatment provided in our office for this patient."

Amount in Dispute: \$2,420.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Previously paid \$4,029.12. An additional payment is being issued in the amount of \$167.00."

Response Submitted by: Sentry Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2015	Dental Services	\$2,420.72	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.303 sets out the 2005 Dental Fee Guideline.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' Compensation jurisdictional fee schedule adjustment.
 - W3 – Request for reconsideration.

Issues

1. Did the insurance issue payment to the requestor for date of service September 1, 2015 pursuant to 28 Texas Administrative Code §134.303?
2. Is the requestor entitled to additional reimbursement for D0220, D0230, D2740 x 3 and D2950 x 3.
3. Did the requestor submit documentation to support the fair and reasonable reimbursement for dental code D6057?

Findings

1. The Requestor seeks additional reimbursement for preauthorized dental services rendered on September 1, 2015. 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 W3 – Request for reconsideration.”

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 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%.”

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:

DENTAL CODE	TX MEDICAID FEE SCHEDULE	TX WORKERS' COMPENSATION FEE SCHEDULE	Insurance Carrier Paid	ADDITIONAL RECOMMENDED PAYMENT
D0220	\$12.82	\$12.82 X 200% = \$25.64	\$25.64	\$0.00
D0230	\$11.74	\$11.74 X 200% = \$23.48	\$23.48	\$0.00
D2740 X 3	\$264.00	\$264.00 X 200% = \$528.00 \$528.00 X 3 = \$1,584.00	\$528.00 X 3 = \$1,584.00	\$0.00
D2950 X 3	\$45.00	\$45.00 X 200% = \$90.00 \$90.00 X 3 = \$270.00	\$90.00 X 3 = \$270.00	\$0.00
D0657	Unvalued	Unvalued	\$700.00	\$0.00
TOTAL		\$1,903.12	\$2,603.12	\$0.00

2. The Division finds that the insurance issued payment to the requestor pursuant to 28 Texas Administrative Code §134.303 (c). As a result, additional reimbursement for the disputed services indicated above cannot be recommended.

3. The requestor seeks additional reimbursement for disputed unvalued dental code D6057. 28 Texas Administrative Code §134.303 states in pertinent part, “(e) In all cases, reimbursement shall be the lesser of the: (c) To determine the maximum allowable reimbursements (MARs), the following apply... (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”

Review of the Texas Medicaid Dental Fee Schedule revealed that dental code D6057 does not have an established value. Review of the submitted documentation documents that the requestor billed the insurance carrier the amount of \$867.00 for dental code D6057. The insurance carrier issued a payment in the amount of \$700.00. Further review of the submitted documentation finds that the requestor submitted insufficient documentation to support that the insurance carrier’s payment was not in accordance with 28 Texas Administrative Code 134.303. As a result, the requestor is not entitled to additional reimbursement for dental code D6057.

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

December 9, 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, 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.