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
Daniel C Bush DDS

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-19-0134-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting an additional payment in the amount of $1501.41 to cover the full amount of treatment cost for date of service June 27, 2018. Dr. Bush is not in network with any insurance company and does not negotiate his fees."

Amount in Dispute: $1,501.41

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In conclusion, no additional reimbursement is should allowed as Requestor has been overpaid pursuant to the Texas Dental Fee Schedule."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 27, 2018	D6740, D6245, D2950, D6740	$1,501.41	$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 §134.403 sets out the 2005 Dental Fee Schedule
3. 28 Texas Administrative Code §134.1 sets out the medical reimbursement
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - TX790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - TXP12 – Workers' compensation jurisdictional fee schedule adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Is the insurance carrier's reduction of the services in dispute supported?

Findings

1. The requestor is seeking additional reimbursement for dental services rendered on June 27, 2108 in the amount of $1,501.41. The insurance carrier reduced the submitted charges as TX790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline" and P12 – "Workers' compensation jurisdictional fee schedule adjustment."

   28 TAC §134.403 (b) (c) (1) states,

   > (b) 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.
   >
   > (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%.

   Review of the Texas Medicaid Fee Schedule for the Date of Service in dispute is as follows:

Date of Service	Dental Code	Billed Amount	Dental Fee Schedule	Maximum allowable reimbursement	Insurance Carrier Paid
June 27, 2018	D6740	$1,240.00	$258.72	$258.72 x 200% = $517.44	$1,240.00 $528.00
June 27, 2018	D6245	$1,220.00	$258.72	$258.72 x 200% = $517.44	$4.17 $528.00
June 27, 2018	D2950	$281.00	$44.10	$44.10 x 200% = $88.20	$4.42 $90.00
June 27, 2018	D6740	$1,240.00	$258.72	$258.72 x 200% = $517.44	$1,240.00 $528.00
Total		$3,990.00	$820.26	$1,640.52	$4,162.59

   The total allowed amount based on the applicable DWC fee guideline is $1,640.52. The carrier paid $4,162.59. No additional reimbursement 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 11, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.