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
RAJESH GUTTA, DDS

Respondent Name
EVEREST NATIONAL INSURANCE CO

MFDR Tracking Number
M4-21-1567-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 5, 2021

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary.

Amount in Dispute: $7,053.87

RESPONDENT'S POSITION SUMMARY

"That reimbursement was based upon the Medical Fee Guidelines…The carrier's position remains the same as it was on EOR dated January 19, 2021. The provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2020	CPT Code 21390 Dental Services	$3,218.71	$0.00
	CPT Code 21422 Dental Services	$3,835.16	$0.00
TOTAL		$7,053.87	$0.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.303, effective June 9, 2005, sets the reimbursement guidelines for the disputed services.
3. 28 TAC §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care would be fair and reasonable.
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 78-The allowance for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
- 59-Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable fee guideline for dental services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for disputed services is found at 28 TAC §134.303.
2. According to the submitted explanation of benefits, the respondent paid $2,332.13 for the disputed services based upon the fee guideline.

   28 TAC §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."

   On the disputed date the requestor billed codes 21390 and 21422.

   28 TAC §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%."

   The DWC finds the following:

   - Code 21390 has a fee of $613.73 ; therefore, $613.73 X 200% = $1,227.46. The respondent paid $1,664.29. An overpayment of $436.83.
   - Code 21422 has a fee of $507.08 ; therefore, $507.08 X 200% = $1,014.16. The respondent paid $667.84. The difference between MAR and amount paid is $346.32.
   - Based upon the above, the DWC finds the requestor is not due additional reimbursement for dental services rendered on September 4, 2020.

Conclusion

For the reasons stated above, the DWC 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/01/2021 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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.