



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Katy Center for Oral & Facial

**Respondent Name**

Phoenix Insurance Co

**MFDR Tracking Number**

M4-22-0264-01

**Carrier's Austin Representative**

Box Number 5

**DWC Date Received**

October 8, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 4, 2021	D0330	\$17.84	\$0.00
February 4, 2021	D9310	\$118.84	\$0.00
February 10, 2021	21453	\$4612.42	\$0.00
February 10, 2021	D7210	\$234.54	\$0.00
April 26, 2021	D9612	\$148.00	\$0.00
April 26, 2021	00170	\$256.00	\$0.00
April 26, 2021	00170	\$256.00	\$0.00
April 26, 2021	00170	\$256.00	\$0.00
April 26, 2021	00170	\$256.00	\$0.00
April 26, 2021	20694	\$760.42	\$0.00
<b>Total</b>		<b>\$6916.06</b>	<b>\$0.00</b>

### Requestor's Position

The requestor did not submit a position statement with their request for MFDR.

**Amount in Dispute:** \$6,916.06

### Respondent's Position

"The Carrier has reviewed the calculations and determined the Provider was properly reimbursed consistent with the relevant Division-adopted fee schedule. The Provider is not entitled to additional reimbursement for the disputed services."

Response submitted by: Travelers

## **Findings and Decision**

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.10 sets out the billing requirements for professional medical claims.
3. 28 TAC §134.203 sets out the fee guidelines for professional medical services.
4. 28 TAC §134.1 defines fair and reasonable reimbursement.

### Denial Reasons

- 16-Claim/service lacks information which is needed for adjudication.
- 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- 5458-The medical report does not substantiate the billed charge.
- 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 76-Billing is greater than surgical service fee.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- W3-Additional payment made on appeal/reconsideration.
- 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 863-Reimbursement is based on the applicable reimbursement fee schedule.

### Issues

1. Is the insurance carrier's denial(s) supported for codes D9612 and 00170?
2. Did the insurance carrier make a fair and reasonable reimbursement for codes D0330, D9310, and D9612?
3. What rule is applicable to codes 21453 and 20694?

4. Is Katy Center for Oral & Facial Surgery entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution for oral surgery services rendered in February and April of 2021. Review of the submitted medical bills finds the claims were submitted on CMS 1500 claim forms with a place of service of 11 – Office.

Based on the submitted medical bills these professional services are subject to reimbursement guidelines found in DWC Rule 28 TAC §134.203.

The insurance carrier reduced the payment amount based on fee schedule adjustment and denied charges as medical report did not substantiate and bundled value.

Review of the submitted DWC060 found the following codes listed as in dispute.

- Code D0330 – Panoramic film
- Code D9310 – Dental consultation
- Code D7210 – Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth
- Code D9612 – Therapeutic parenteral drugs two or more administrations, two different medications
- Code 00170 – Anesthesia for intraoral procedure

The insurance carrier denied code D9612 as claim lacking information. Review of the submitted medical bill found the medical bill lacked a diagnosis, date of service and information to indicate the medications administered. Additionally, the submitted operative report does not support the administration of the parenteral drugs. The insurance carrier's denial is supported. No additional payment is recommended.

The insurance carrier denied the claim for 00170 as the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Review of the submitted medical bill found no required modifier. The insurance carrier's denial is supported. No additional payment is recommended.

2. Upon reconsideration the insurance carrier paid codes D7210, D9310, and D0330 based on the Workers' Compensation Jurisdictional Fee Schedule.  
As previously stated, the applicable fee guideline for professional services rendered in an office setting is found at DWC Rule 28 TAC §134.203 (c) which states in pertinent part, to determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories Surgery when performed in an office setting, the established conversion factor to be applied is (applicable date of service yearly conversion factor.)  
Review of the Medicare physician's fee schedule found codes D7210, D9310, and D0330 are not priced on this fee schedule. DWC Rule 134.203 (h) states, "When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

(1) MAR amount;

- (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or
- (3) fair and reasonable amount consistent with the standards of §134.1 of this title.”

Review of the explanation of benefits dated June 25, 2021, indicates the following.

- D7210, the insurance carrier paid \$196.46
- D9310, the insurance carrier paid \$29.16
- D0330, the insurance carrier paid \$130.16

DWC Rule 28 TAC 134.1(f) required the health care provider to support their suggested reimbursement is:

- consistent with the criteria of Labor Code §413.011;
- by providing documentation of similar procedures provided in similar circumstances received similar reimbursement; and
- their suggested reimbursement is based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Review of the submitted documentation found insufficient information to support how the amounts requested by the provider above the value assigned and paid by the insurance carrier would meet the fair and reasonable requirements. No additional payment is recommended.

3. The requestor is seeking additional reimbursement of code 21453 – Treatment of mandibular fracture for date of service February 10, 2021, and 20694 – Removal of hardware for date of service April 26, 2021. These codes are found on the physician fee schedule. DWC Rule 134.203 (c) referenced above details the maximum allowable reimbursement is calculated as.

The applicable physician fee schedule amount for date of service and service location multiplied by the DWC conversion factor divided by the DWC conversion factor or,

Code 20694 -  $\$421.88 \times 61.17/34.8931 = \$739.58$ .

Code 21453 -  $\$1076.73 \times 61.17/34.8931 = \$1887.58$ .

4. The total MAR for the disputed services is \$2,627.16. The insurance carrier paid \$2,627.16. No additional reimbursement is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July 25, 2022

\_\_\_\_\_  
Date

**Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).