Division of Workers' Compensation

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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Diais, Shihab Mufleh

Respondent Name
Hartford Underwriters Insurance Co

MFDR Tracking Number
M4-23-2798-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
July 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2023	D2740	$1295.50	$0.00
January 3, 2023	D2740	$1295.50	$0.00
January 3, 2023	D2950	$309.00	$0.00
January 3, 2023	D2950	$309.00	$0.00
January 3, 2023	D3310	$314.72	$0.00
January 3, 2023	D3310	$314.72	$0.00
	Total	$3838.44	$0.00

Requestor's Position

"…we received payment for $2,577.56 instead of the total $6,416.00. While there is an expectation of some deduction, the payment should have been a minimum of at least 85% to 90% of our charges."

Amount in Dispute: $3838.44

Respondent's Position

"The Medical Fee Guidelines provide for the payment of 200% of the CMS fees. The following are the CMS fees:

D2740 Medicaid fee equals $252.25 x $200% = $504.50

D2950 Medicaid fee equals $43.00 x 200% = $86.00

D3310 Medicaid the [sic] equals $340.14 x 200% = $680.28

These are the amounts that were paid based upon the carrier's EOB dated July 4, 2023, which is part of the provider's DWC-60 packet. The provider is not entitled to any additional payment."

Response submitted by: Flahive, Ogden & Latson

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 §134.303 sets out the fee guidelines for dental services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 00663 – Reimbursement has been calculated according to State Fee Schedule Guidelines.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 90223 – Workers Compensation Jurisdictional fee schedule adjustment.
- 93 – No claim level adjustments
- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. What rule is applicable to reimbursement?
2. Is the requestor due additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for dental services rendered in January of 2023. The insurance carrier reduced the allowance based on the workers' compensation fee schedule.

DWC Rule 134.303 (c) (1) states.

1. The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%.

Review of the submitted ADA Claim form found the following claim lines.

- JP 8, D2740 (1) Full Porcelain/Ceramic Crown $1800.00
- JP 9, D2740 (1) Full Porcelain/Ceramic Crown $1800.00
- JP 8, D2950 (1) Core Buildup w/Any Pins $395.00
- JP 9, D2950 (1) Core Buildup w/Any Pins $395.00
- JP 8, D3310 (1) Root Canal Therapy on Anterior $995.00
- JP 9, D3310 (1) Root Canal Therapy on Anterior $995.00

Review of the Texas Medicaid Fee Schedule found the following allowable.

- D2740 allowable $252.25
- D2950 allowable $43.00
- D3310 allowable $340.14

The DWC fee guideline amounts are.

- $252.25 x 2 units x 200% = $1,009.00.
- $43.00 x 2 units x 200% = $172.00.
- $340.14 x 2 units x 200% = $1,360.56
- Total allowable $2,541.56.

2. The total allowable for the disputed services based on the DWC fee guidelines is $2,541.56. Review of the submitted explanation of benefits found the insurance carrier paid $2,541.56. No additional payment 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 requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		August 31, 2023
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 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. 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.

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 electronico CompConnection@tdi.texas.gov.