TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Christina Maria Greene, DDS

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-25-0414-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
October 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2023	D0150	$126.00	$0.00
November 2, 2023	D0220	$41.00	$0.00
November 2, 2023	D0230	$34.00	$0.00
November 2, 2023	D0274	$87.00	$0.00
November 2, 2023	D0330	$150.00	$0.00
November 2, 2023	D0367	$250.00	$0.00
November 29, 2023	D0220	$41.00	$0.00
November 29, 2023	D7961	$350.00	$0.00
November 29, 2023	D9248	$350.00	$0.00
November 29, 2023	D2740	$1525.00	$0.00
November 29, 2023	D2950	$268.00	$0.00
November 29, 2023	D2393	$348.00	$0.00
November 29, 2023	D2392	$284.00	$0.00
November 29, 2023	D2330	$228.00	$0.00
November 29, 2023	D2740	$1525.00	$0.00
November 29, 2023	D2950	$268.00	$0.00
November 29, 2023	D3310	$1284.00	$0.00
November 29, 2023	D2332	$333.00	$0.00
November 29, 2023	D6010	$2528.00	$0.00
November 29, 2023	D6010	$2528.00	$0.00

November 29, 2023	D7140	$268.00	$0.00
November 29, 2023	D6010	$2528.00	$0.00
November 29, 2023	D6010	$2528.00	$0.00
November 29, 2023	D7140	$268.00	$0.00
November 29, 2023	D6010	$2528.00	$0.00
December 20, 2023	64646	$360.00	$0.00
April 4, 2024	64646	$240.00	$0.00
July 29, 2024	64646	$288.00	$0.00
July 29, 2024	D6057	$1284.00	$1284.00
July 29, 2024	D6058	$1808.00	$1808.00
July 29, 2024	D6057	$1284.00	$1284.00
July 29, 2024	D6058	$1808.00	$1808.00
July 29, 2024	D6057	$1284.00	$1284.00
July 29, 2024	D6058	$1808.00	$1808.00
	Total	$27,097.82	$9,276.00

Requestor's Position

The requestor did not submit a position statement with their request for MFDR. The requestor submitted a copy of their reconsideration dated July 17, 2024, which states, "I am requesting reconsideration of payment of medical bills for the following claims that are attached to this letter. These claims have been sent multiple times… …I have had multiple conversations on the phone with Mitchell Griffin and have been informed that since the patient (redacted) went to your assigned provider who agreed with my treatment and the patient's diagnosis, that the claims must be paid. I have been following up on these claims every single week and am still yet to receive payment."

Amount in Dispute: $27,097.82

Respondent's Position

"Upon receiving notification of the dispute submitted by the requestor Christina Greene DDS the Office reviewed the disputed charges and determined we will maintain our denial and our fair and reasonable payments made thus far for the dates in dispute. There is no evidence in the dispute packet to support the two criteria outlined in Texas Labor Code §408.0272(b), (c), or (d) to apply toward a timely waiver."

Response submitted by: SORM

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §102.4 sets out the guidelines for communications.
3. 28 TAC §133.20 sets out the billing guidelines for medical services.
4. Texas Labor Code 408.0272 sets out the exceptions to timely filing.
5. 28 TAC 134.403 sets out the medical fee guidelines for dental services.

Denial Reasons

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

- 16 – Claim/ service lacks information which is needed for adjudication
- 29 – The time limit for filing has expired.
- 251 – The attachment content received did not contain the content required to process this claim or service.
- 18 – Exact duplicate claim/service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 96 – Non-covered charges.
- Remark – There is no medical to support or establish that treatment is for the compensable injury as there has been no treatment and has been inactive for 20 years.
- Remark – The provider has resubmitted this bill, but has removed/changed the diagnosis code, CPT/HCPC code(s), POS and/or total bill charge amount.
- Remark – Please resubmit with a valid CPT code for review.

Issues

1. Did the respondent maintain their statement of non-compensability?
2. Is additional payment due for date of service April 24, 2024?
3. Is additional payment due for date of service December 20, 2023?
4. Is additional payment due for date of service November 2, 2023?
5. Is additional payment due for date of service November 29, 2023?
6. Is additional payment due for date of service July 29, 2024?

Findings

1. The respondent states in their response to MFDR, "There was no medical on this file to

support services were compensable as the claim closed on 12/8/2000 and there had been no treatment on this claim since 9/18/2000." The explanation of benefits also contained the statement, "There is no medical to support or establish that treatment is for the compensable injury as there has been no treatment and has been inactive for 20 years."

Review of the submitted documents found while the submitted documentation included copies of PLN1 and a Benefit Review Conference based on compensability, the insurance carrier adjudicated the claims as follows.

2. The requestor is seeking reimbursement of the following dental bills.

Date of service April 24, 2024, claim total $6,708.00. The insurance carrier received the medical bill on May 2, 2024, the insurance carrier denied the claim as 16 – Claim/service lacks information which is needed for adjudication on May 17, 2024. Additional documentation found the requestor was notified by SORM on May 3, 2024, that the claim was being returned as "incomplete."

SORM made a payment of $5,852.18 on May 21, 2024, in the amount of $5,852.18 via warrant number 148095961. After the payment referenced above only the charge billed under 99199, with a billed amount $240.00 was denied as 16 – "Claim/service lacks information which is needed for adjudication," and remains in dispute.

SORM notified the requestor of the need to resubmit with a valid CPT code for further review on May 3, 2024.

Review of the submitted documentation found an explanation of benefits printed September 26, 2024, for billed code 64646 – (Destruction by Neurolytic Agent) (originally billed under code 99199) in the amount of $240 for date of service April 24, 2024. The insurance carrier denied the claim line as not submitted timely.

DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

(1) the date received if sent by fax, personal delivery, or electronic transmission; or

(2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to submit a timely claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found the date of service April 24, 2024, in the amount of $240 was received by the insurance carrier on September 13, 2024. The greater weight of evidence supports the medical bill was not submitted timely and there is insufficient information to support an exception described above. No payment is recommended.

3. Date of service December 20, 2023, claim total $360.00. Review of the submitted documentation found a dental claim for date of service December 20, 2023, with the word (Botox) listed in box 29. SORM indicates this claim was received April 22, 2024. SORM notified the requestor that the claim was missing information on May 3, 2024 (valid CPT code for further review). An explanation of benefits printed September 26, 2024, indicates that a medical bill for code 64646 - Destruction by Neurolytic Agent, was denied with claim adjustment code 29 – "The time limit for filing has expired". This complete medical bill was received on September 13, 2024. Addressed in the rule above, the requestor was required to submit a complete medical bill within 95 days of the date of service. The greater weight of evidence finds the charge for date of service December 20, 2023, was submitted in September 2024 which is beyond the 95-day time limit. The insurance carrier's denial is supported. No payment is recommended.

4. Date of service November 2, 2023, claim total $688.00. SORM indicates that the carrier received the claim on April 22, 2024. The claim adjustment codes on the explanation of benefits dated April 25, 2024, are 29 – The time limit for limit for filing has expired, 16 – Claim/service lacks information which is needed for adjudication, and 251 – The attachment content received did not contain the content required to process this claim or service. The requestor was required to submit the medical bill withing 95 days of the date of service. The greater weight of evidence supports a complete medical bill was submitted on April 22, 2024. This date is beyond 95 days of the disputed date of service November 2, 2023. The insurance carrier's denial is supported. No payment is recommended.

5. Date of service November 29, 2023, claim total $20,543.00. SORM indicates that the claim was received on December 13, 2023. The claim adjustment codes on the explanation of benefits dated December 27, 2023, are 251 – The attachment content received did not contain the content required to process this claim or service and 16 – Claim/service lacks information which is needed for adjudication. Review of the submitted documents found an explanation of benefits dated September 26, 2024, that indicates the claim was received on September 13, 2024. This date is beyond the 95th day after the date the requestor was required to submit a complete medical bill. The insurance carrier's denial is supported no additional payment is recommended.

6. Date of service July 29, 2024, claim total $9609.00. SORM indicates the claim was received on August 1, 2024, and a payment of $262.34 was made on code D2332 via Check on August 14, 2024, warrant number 148983229. Code D6057- custom-fabricated abutment and D6058 – abutment-supported porcelain/ceramic crown billed three times each were denied as 96 – Non-covered charges. SORM indicates in their response to MFDR, "Paid following Texas Medicaid fee schedule allowances. No negotiation rates were agreed upon to pay procedure codes D6057 and D6058 as these codes are non-reimbursable in the TX Medicaid Fee Schedule."

   DWC Rule 28 TAC §134.303 (c)(2) states, 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.

   DWC Rule 28 TAC §134.303 (e) 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).

   Based on the above-mentioned rule the insurance carrier's denial and position are not supported.

   The disputed codes do not have an allowable in the Texas Medicaid Dental Fee Schedule, no MAR can be calculated. There was insufficient evidence to support a negotiated or contract amount.

   The amount submitted on the medical bill indicates the health care provider's usual and customary charge for Code D6057 is $1284. This amount multiplied by 3 equals an allowed reimbursement amount of $3,852.00

   The amount submitted on the medical bill indicates the health care provider's usual and customary charge for Code D6058 is $1808.00. This amount multiplied by 3 equals an allowed reimbursement amount of $5,424.

   The allowable reimbursement for Code D6058 and D6057 for date of service July 29, 2024, is $9,276.00. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled

to additional reimbursement for the disputed services. It is ordered that SORM must remit to Christina Maria Greene $9,276.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 13, 2024 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.