



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Barksdale & Hastings DDS

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-25-0679-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

November 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 23, 2024	D0220	\$13.36	\$0.00
May 23, 2024	D2750	\$314.00	\$0.00
May 23, 2024	D2750	\$314.00	\$0.00
Total		\$641.36	\$0.00

Requestor's Position

"The workers comp insurance did not cover the total charges. I am not sure why we should be asked to write off any differences. If we knew we weren't going to be paid our standard fee, we would not have provided these services. I ask that you consider keeping us whole in this matter and ask that a speedy resolution be determined in order that we can put this matter to rest."

Amount in Dispute: \$641.36

Respondent's Position

"It is the carrier's position that the provider has been paid all of the monies the provider is entitled to."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §134.303](#) sets out the procedures for dental medical bills.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for dental services rendered in May of 2024. The insurance carrier reduced the services based on workers' compensation jurisdictional fee schedule. DWC Rule §134.303 (b) and (c)(1) 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. To determine the maximum allowable reimbursements (MARs), the following apply: The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%.

Review of the TMHP (Texas Medicaid) fee schedule at <https://public.tmhp.com/FeeSchedules>, found the following.

- D0220 – Medicaid fee $\$12.56 \times 200\% = \25.12
- D2750 – Medicaid fee $\$504.50 \times 200\% = \$1,009.00 \times 2 = \$2,018.00$
- Total allowable fee applicable DWC Rule shown above is $\$2,043.12$. The insurance carrier paid $\$2,043.64$. 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 entitled to \$0.00 reimbursement for the disputed services

Authorized Signature

_____	Medical Fee Dispute Resolution Officer	January 31, 2025
Signature		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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.