



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

ALLIED MEDICAL CENTERS

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 12, 2011

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-11-3093-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "pre auth on cms 1500 since initial fax."

Amount in Dispute: \$162.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual [claim number] is in the Texas Star Network... Cumulative Chiropractic Treatments (including manipulations and office visits) greater than 14 visits and/or greater than 10 weeks from date of injury require preauthorization on a Network claim... For these reasons no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2010	99203	\$162.00	\$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.

Background

- 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code §133.307, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
- 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network.

Issues

- Are the disputed services rendered to an in-network injured employee?
- Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?
- What may be the appropriate administrative remedy to address fee matters related to health care certified networks?

Findings

1. The requestor billed for CPT code 99203 rendered on May 12, 2010 to an injured employee enrolled in a certified healthcare network. The Division notified the requestor on September 4, 2014 that the disputed services were provided to an injured employee enrolled in a certified network. The notification letter contained information/documentation outlining the dispute path for in-network providers and out-of-network providers. Documentation found indicates that the health care provider in this case treated an injured employee enrolled in a *certified network*. The requestor did not submit a response and/or submitted insufficient documentation to the Division to support that the disputed services are eligible for review by Medical Fee Dispute Resolution.
2. 28 Texas Administrative Code §133.305 (a) (4) defines a medical fee dispute as “A dispute that involves an amount of payment for **non-network** health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee’s compensable injury. The dispute is resolved by the Division pursuant to Division rules, including §133.307 of this subchapter (relating to MDR of Fee Disputes).” Non-network health care is defined in Section (a) (6) of the same rule as “Health care not delivered, or arranged by a certified workers compensation health care network as defined in Insurance Code Chapter 1305 and related rules...”
 Per 28 Texas Administrative Code §133.307 (a) (3) “...In resolving non-network disputes which are over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers’ Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.” Adjudicating the fees for the disputed service(s) would involve enforcing a law, regulation, or other provision related to the price of CPT code 99203 provided to an injured employee enrolled in a *certified network*. The Division finds the disputed services are not under the jurisdiction of the Division of Workers’ Compensation and therefore are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.
3. The TDI rules at 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The Division finds that the disputed services rendered by an in-network healthcare facility to an in-network injured employee may be filed to the Texas Department of Insurance’s (TDI) Complaint Resolution Process, if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. The Division finds that this dispute is not under the jurisdiction of the Division of Workers’ Compensation and is therefore not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

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