



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON HOSPITAL FOR SPECIALIZED SURGERY

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 28, 2013

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-13-2459-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was denied for no authorization... We as the provider did our due diligence and verified we, the provider, are in-network providers and that no authorization is required for the services. Therefore, we ask that this claim be retroactively authorize the procedures and allow proper reimbursement."

Amount in Dispute: \$19,733.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided non-emergency outpatient surgery services to the claimant on the date above then billed Texas Mutual for this. Upon receipt of the bill Texas Mutual reviewed the bill and attached documentation, then reviewed its claim file for preauthorization. None was found; therefore was declined."

Response Submitted by: Texas Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
February 11, 2013	Outpatient Facility Charges	\$19,733.27	\$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 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.

Issue

- Did the requestor receive a referral approval from the certified network to treat the injured employee?
- Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

- 1. Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

Texas Insurance Code Section 1305.103 requires that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I."

The requestor has the burden to prove that it obtained the appropriate network approved referral for the out-of-network healthcare it provided. Review of the submitted documentation finds that the requestor submitted insufficient documentation and/or no documentation to support that a referral was obtained from the treating doctor, approved by the network to treat the injured employee. The Division concludes that the requestor thereby has failed to meet the requirements of Texas Insurance Code Section 1305.103.

- 2. The Division finds that the requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

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 not all the evidence was 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.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 14, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).