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
TEXAS HEALTH ALLIANCE

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 26, 2014

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-14-3245-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All documentation has been provided for accurate review. Services have been provided to the patient to further help resume his duties for employment, we feel we have taken the necessary steps to help him through the process...Therefore, we request that this bill be reconsidered for prompt payment."

Amount in Dispute: $532.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical treatment in this case was delivered or arranged by a certified healthcare network, First Health Texas HCN. Medical fee dispute under Rules 133.305 and 133.307 is appropriate only for non-network claims. The treatment at issued in this case was delivered or arranged by a certified healthcare network by the Requestor... Accordingly, the Division has no jurisdiction over this fee dispute and this action should be dismissed."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2014 through April 24, 2014	99213, 99080-73 and 99455-VR	$532.00	$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

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 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

1. Are the disputed services rendered by an in-network healthcare provider/facility to an in-network injured employee?
2. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305?
3. What may be the appropriate administrative remedy to address fee matters related to health care certified networks?

Findings

1. The requestor billed for CPT codes 99213, 99080-73 and 99455-VR rendered January 10, 2014 through April 24, 2014 to an injured employee enrolled in a certified healthcare network. The Division notified the requestor on September 8, 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. Review of the documentation in this dispute supports 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 that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (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 …"

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 §133.305.

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

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, effective May 31, 2012, *37 Texas Register 3833*, **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).