



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

SETON NORTHWEST HOSPITAL

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MARCH 2, 2015

Respondent Name

TEXAS MUTUAL INSURANCE CO.

MFDR Tracking Number

M4-15-1948-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor provided services to [injured worker] (hereinafter Claimant) on the date of. [sic] 4/16/2014 The charges incurred in the course of the Claimant's treatment totaled \$ 6,023.00 At that time, hospital staff was advised by [employer] (hereinafter employer') that it had not yet reported the injury to its workers compensation carrier. The employer asked to receive the hospital's bill indicating that they would send it to the workers compensation carrier along with the report of injury. These charges were billed to and subsequently denied by the Carrier. It was Carrier's contention that the 'the time limit for filing has expired."

Amount in Dispute: \$827.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim 1425000911831 and SETON NORTHWEST HOSPITAL are participants in the Texas Star Network. Rule 133.305(a)(5) defines a medical fee dispute as one that involves '...an amount of payment for non-network health care... The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes)...' Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resoluition through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2014	Outpatient Hospital Services	\$827.20	\$ 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 and §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service,

for services on or after 9/1/05.

- W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Did the in-network healthcare provider render services 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?
4. Where can complaints to the health care certified network be made?

Findings

1. The insurance carrier's response indicates that both the healthcare provider and the injured employee are enrolled in the Texas Star Network.
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 the treatment of that employee's compensable injury." Non-network health care is defined in Section (a) (5) of the same rule as "Health care not [emphasis added] delivered, or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules..."

28 Texas Administrative Code §133.307 (a) (1) similarly states that "This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care..." Therefore, the division's medical fee dispute resolution section may not address fee disputes involving health care delivered, or arranged by a certified network as defined by Insurance Code Chapter 1305, but may resolve disputes involving certain authorized out-of-network health care.

Information found in the above-named medical fee dispute indicates that the injured employee treated is enrolled in a health care certified network (HCN). The authority of the Division's Medical Fee Dispute Resolution (MFDR) is to resolve disputes involving HCN is limited to the condition(s) outlined in Texas Insurance Code §1305.006.

3. Out-of-network health care is defined at Insurance Code Chapter 1305, section 1305.006 titled Insurance Carrier Liability for Out-of-Network Health Care. No documentation was found to support that the health care in dispute is authorized, out-of-network health care pursuant to Insurance Code Chapter 1305. This dispute may not be resolved pursuant to 28 Texas Administrative Code §133.307; for that reason, no additional reimbursement can be recommended.
4. Complaint to the health care certified network: Texas Department of Insurance (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 HCN. Complaint to TDI: Health care providers may file a complaint to the Texas Department of Insurance if they are dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 is the appropriate administrative remedy to address fee matters related to health care certified networks.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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

Date

May 28, 2015

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.