



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

KINDRED HOSPITAL SAN ANTONIO

MFDR Tracking Number

M4-16-2050-01

MFDR Date Received

March 18, 2016

Respondent Name

VALLEY FORGE INSURANCE CO

Carrier's Austin Representative

Box Number 47

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Prior to the Patient's admission to Kindred's hospital, Kindred contacted CAN to verify coverage and the terms of payment. CNA advised Kindred that coverage was available, that payment would be made according to the Coventry Healthcare ('Coventry') network contract, and that Kindred should contact Coventry to obtain pre-authorization. Kindred is a participating provider through its contract with Coventry and, as such, expected to receive payment for its care and treatment of the Patient at the Coventry contract rate of 90% of the Texas workers' compensation reimbursement amount."

Amount in Dispute: \$105,667.26

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As indicated in our prior response dated April 8, 2016, the Carrier has determined that no additional reimbursement is owed. The bill was originally audited and the Explanation of Review resulted in the recommended allowance of \$36,005.79. A request for reconsideration was submitted on May 18, 2015 which resulted in an additional allowable of \$30,567.96. As such, a total amount of \$66,573.75 was processed... Because this relates to healthcare provided through a workers compensation healthcare network, Rule 134.404 is inapplicable and the Division does not have jurisdiction over this claim."

Response Submitted by: Law Offices of BRIAN J JUDIS

SUMMARY OF FINDINGS

Table with 4 columns: Date(s) of Service, Disputed Service(s), Amount In Dispute, Amount Due. Row 1: January 24, 2015 to March 19, 2015; Inpatient Hospital Services; \$105,667.26; \$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. 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?

**Findings**

1. The requestor billed for Inpatient Hospital Services rendered on January 24, 2015 to March 19, 2015 to an injured employee enrolled in a certified healthcare network. The requestor seeks a decision from the Division’s medical fee dispute resolution (MFDR) section. The Division finds that the disputed services were rendered by an in-network healthcare provider to an in-network injured employee.
2. The authority for MFDR to resolve matters involving employees enrolled in a certified health care network is conditional. 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.” The Division defines non-network health care in paragraph (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 ...” That is, the Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

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 finding 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 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**

		4/29/16
Signature	Medical Fee Dispute Resolution Officer	Date

		4/29/16
Signature	Medical Fee Dispute Resolution Director	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).