



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION**

Requestor Name

PHYSICIAN MANAGEMENT SERVICES
DBA INJURY 1 TREATMENT CENTER

MFDR Tracking Number

M4-18-0146-01

MFDR Date Received

September 18, 2017

Respondent Name

INDEMNITY INSURANCE COMPANY

Carrier's Austin Representative

Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance company has not paid the CPT codes 97545 and 97546 correct. I have attempted to settle dispute but the carrier still has not paid the claims correct."

Amount in Dispute: \$1,771.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier requests that the Provider withdraw this dispute after the payment of the additional \$158.40 is received."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
March 27, 2017 through April 6, 2017	97545-WH-CA and 97546-WH-CA	\$1,771.20	\$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

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 CPT Codes 97545-WH-CA and 97546-WH-CA rendered on March 27, 2017 through April 6, 2017 to an injured employee enrolled in a certified healthcare network. 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.

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. Review of the submitted documentation submitted for review supports that the requestor is a participant in the certified network associated with this claim. The Division finds that this is not an out-of-network situation, as the injured employee and the health care provider are both in network. As a result, the medical fee dispute is not eligible for medical fee dispute resolution review under 28 Texas Administrative Code §133.307.

2. 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.

FINDINGS

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 not eligible for Medical Fee Dispute Resolution under 28 Texas Administrative Code §133.307.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

January 5, 2018
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).