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
WRIGHT W SINGLETON MD

MFDR Tracking Number
M4-18-0806-01

MFDR Date Received
November 27, 2017

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These are mostly MMI/IR [sic] for Texas Star... I was promised payment by both Texas Star and Coventry on many occasions but no payment was ever received. Their excuse was that my tax ID was changed... My question was how was it changed in the first place without my permission but with my demand in writing to correct it; they refused... I spoke with adjuster for Texas Mutual who said if I sent in my recent tax form W9 that would solve the issue. I did this no payment was received."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Claim [claim #] is in the Texas Star Network. (Attachment 1). Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification (Tax ID) number, and found evidence WRIGHT W SINGLETON MD PLLC is a participant in that Network under tax identification number [Tax ID#]...However, Dr. Singleton billed with Tax ID [Tax ID#] which is not in that Network... Because this fee reimbursement dispute involves a Network requirement under the Insurance Code and not the Labor Code, Texas Mutual argues DWC MDR has no jurisdiction in this matter. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 20, 2017	99456-RE	$150.00	$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 §133.307 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.

Findings

Dr. Wright W. Singleton billed for CPT Code 99456-RE (no show fee), for an injured employee covered by the Texas Star Network. His bills were denied by Texas Star. Dr. Singleton filed for medical fee dispute and asserts that payment should be made. According to the respondent, the tax identification number on Dr. Singleton's bill for the service in dispute was different than the tax identification number that Texas Star Network had on its contract records. For that reason, Texas Star Network denied payment. Dr. Singleton contends that he was unaware of any changes to his status as a contracted provider in Texas Star Network at the time that he performed the services. The Division now considers whether the Division's medical fee dispute resolution process is the appropriate administrative remedy for Dr. Singleton.

1. Is the Division's medical fee dispute resolution process the appropriate administrative remedy to resolve a question regarding a Network contract or procedure?

Medical fee dispute resolution at the Division of Workers' Compensation is not the appropriate administrative process to resolve a question regarding a Network contract or procedure. Pursuant to Texas Insurance Code Subchapter I,[1] the Network compliant process outlined in the policies and procedures of the Texas Star Network is the appropriate remedy (attached). Additionally, the Division notes that Dr. Singleton may also choose to file a complaint with the Texas Department of Insurance.[2]

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 findings 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	December 20, 2017 Date

[1] SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint. (b) The network may require a complainant to file the complaint not later than the 90th day after the date of the event or occurrence that is the basis for the complaint. (c) The complaint system must include a process for the notice and appeal of a complaint. (d) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines. (b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

[2] How does a provider file a Workers' Compensation Network complaint?
When submitting a complaint please include your contact information, the injured employee's name, date of birth, claim number, the name of the Certified Workers' Compensation Network and the reason for the complaint. Be specific when explaining the reason for your complaint and include any supporting documentation. If the complaint involves a claim issue, please submit a copy of the claim form (CMS1500, UB04 or ADA), evidence of your collection attempts and evidence of timely claim filing.

[redacted]

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).