



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DOCTORS HOSPITAL AT RENAISSANCE

MFDR Tracking Number

M4-19-1742-01

MFDR Date Received

November 26, 2018

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative

Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per your explanation of benefits denial reason was for no authorization for the services. Doctors Hospital at Renaissance was not aware authorization was required and denied citing that we are a non-network provider... We rendered services in good faith based on the information that was exchanged and therefore are also requesting that our claim be reprocessed for payment."

Amount in Dispute: \$303.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] is a participant in the Texas Star Network... Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services. The requester obtained out of network authorization to treat. However, the surgical treatment the requestor provided required preauthorization under the network requirements. Texas Mutual reviewed its claim file and found no evidence the requester sought or obtained the required preauthorization nor does the requester's DWC 60 packet provide any evidence of such on the requester's part."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Ordered
August 17, 2018	17250	\$303.18	\$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 §133.307, sets out the procedures for resolving medical fee disputes.
- 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
- The services in dispute were denied by the respondent with reason code(s)
 - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment
 - CAC-197 – Precertification/authorization/notification absent
 - D25 – Approved non-network provider for TX Network claimant per rule 1305.153 (c)
 - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract

Issue

1. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

The requestor filed this medical fee dispute with the Division requesting 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 the Texas Labor Code (TLC) statutes and rules, including 28 TAC §133.307 and is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met to be eligible for dispute resolution. The following are the Division's findings.

The requestor seeks reimbursement for CPT Code 17250 rendered on August 17, 2018. The services in dispute were denied with reduction code(s) CAC-P12, CAC-197, D25 and 786, description provided above.

TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

Per 28 Texas Administrative Code §133.307 (a) (3) "...In resolving **non-network** disputes which are over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules."

The Division finds that adjudicating the disputed service would involve enforcing a law, regulation, or other provision for the disputed service(s), provided to an in-network injured employee. The Division finds the disputed services are not under the jurisdiction of the Division of Workers' Compensation and therefore, are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

The Division finds that the preauthorization issue submitted to Medical Fee Dispute for resolution, is not the appropriate administrative process to resolve a question regarding a Network payment reduction. Pursuant to Texas Insurance Code Subchapter I,¹ the Network complaint process is the appropriate remedy. Additionally, the Division notes that requestor may also choose to file a complaint with the Texas Department of Insurance.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 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.

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.

Then, email the complaint to ConsumerProtection@tdi.texas.gov; or fax to (512) 490-1007; or mail to Texas Department of Insurance, Consumer Protection, MC 111-1A, P.O. Box 149091, Austin, Texas 78714-9091.

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.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2019 Date
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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).