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
DOCTORS HOSPITAL AT RENAISSANCE

MFDR Tracking Number
M4-19-1777-01

MFDR Date Received
November 28, 2018

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate... Payment received was only $4,747.34, thus, according to these calculations; there is a pending payment in the amount of $342.94."

Amount in Dispute: $2,394.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] is a participant in the Texas Star Network... The requester obtained out of network authorization to treat. However, the treatment the physical therapy treatment the requester 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..."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
August 2, 2018 through August 30, 2018	97110, 97530, 97112, 97116 and 97162	$2,394.02	$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 fee disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 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
   - 725 – Approved non-network provider for Texas Star Network claimant per rule 1305.153 (c)

Issue

1. Did the requestor obtain an out of network referral and preauthorization for the disputed services?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

1. 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 to resolve matters involving employees enrolled in a certified health care network is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 TAC §133.307.

   Texas Insurance Code §1305.106 provides that "An insurance carrier that establishes or contracts with a network is liable for the following **out-of-network** health care that is provided to an injured employee... (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   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 Division finds that the requestor obtained an out-of-network referral, however did not obtain preauthorization for the treatment rendered on August 2, 2018 through August 30, 2018. As a result, the disputed services are not eligible for medical fee dispute resolution. 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.

2. The Division finds that the disputed services were rendered to an in-network injured employee. 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 may be filed to the 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 and may be the appropriate administrative remedy to address 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. Even though all the evidence was not discussed, it was considered. 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.

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 Manager	January 24, 2019 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 (**DWC-045M**) 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).