



# 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**

MEMORIAL HERMANN HOSPITAL THE WOODLANDS

**MFDR Tracking Number**

M4-19-4008-01

**MFDR Date Received**

May 1, 2019

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**Carrier's Austin Representative**

Box Number 54

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please note upon pre-registration authorization was obtained; please see our attached file notes. Therefore, I am respectfully requesting a reconsideration and payment of the charges in the amount of \$1,064.25."

**Amount in Dispute:** \$1,064.25

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual claim [claim number] is in the WorkWell Network... Due to lack of preauthorization for the surgical procedure, any preop testing would be considered integral to the surgical service and therefore payment was denied. 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
January 9, 2019	Outpatient Facility Charges	\$1,064.25	\$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 facility 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 outpatient facility charges rendered on January 9, 2019 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 facility to an in-network injured employee.

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 facility was authorized by the certified network to do so. The Division finds that this is not an out-of-network situation, as the injured employee and the facility 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.

Medical fee dispute resolution at the Division of Workers' Compensation is not the appropriate administrative process to resolve a question regarding a Network payment reduction. Pursuant to Texas Insurance Code Subchapter I,<sup>1</sup> the Network complaint process outlined in the policies and procedures of the certified healthcare network is the appropriate remedy. Additionally, the Division notes that requestor may also choose to file a complaint with the Texas Department of Insurance.<sup>2</sup>

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 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

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<sup>1</sup> 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.

<sup>2</sup> 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](mailto: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.

**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	Date
		May 30, 2019

***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 (20)** 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).

***Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.***