



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

METSL LLC

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-19-4211-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

Texas Mutual Insurance Co

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that the adjuster approved a portion of this bill according to the approved attached. Please review the enclosed documents and reprocess the invoice for an allowance of \$39,698.23.

Amount in Dispute: \$99,245.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual claim [claim number] is in the Texas Star Network. (Attachment) Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification number, and found no evidence METSL LLC is a participant in that Network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|----------------------------|-------------------|------------|
| October 01, 2018 | Inpatient Hospital Service | \$99,245.60 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

Issues

1. Did the Requestor obtain an out-of-network referral from the injured employee's treating doctor that was approved by the network pursuant to Section 1305.103?
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 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. In particular, 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."

Texas Insurance Code Section 1305.006 states, in pertinent part, "(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."

The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

Texas Insurance Code Section 1305.103 requires that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I."

2. The requestor has the burden to prove that it obtained the appropriate approved out-of-network referral for the out-of-network healthcare it provided. Review of the submitted documentation finds that the requestor submitted insufficient documentation and/or no documentation to support that a referral was obtained from the treating doctor and approved by the network to treat the injured employee. The Division concludes that the requestor thereby has failed to meet the requirements of Texas Insurance Code Section 1305.103.

The Division finds that the requestor failed to prove in this case that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 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.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature Medical Fee Dispute Resolution Officer 6/28/2019
Date

Signature Director of Medical Fee Dispute Resolution 6/28/2019
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.