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
BAPTIST ST ANTHONY'S HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-20-0226-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

The health care provider did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"Texas Mutual claim… and BAPTIST ST ANTHONYS HEALTH SYSTEM are participants in the WorkWell Network. (Attachment)… Because this is network healthcare Rule 133.307 does not apply."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 7, 2019	Outpatient Hospital Services	$99.00	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the hospital facility fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.240 sets out requirements regarding medical bill payments and denials.
4. 28 Texas Administrative Code §134.600 sets out requirements regarding authorization of health care.
5. Texas Insurance Code Chapter 1305 sets out requirements for workers' compensation health care networks.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 785 – SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION. PREAUTHORIZATION NOT SOUGHT/APPROVAL NOT OBTAINED FOR THAT SERVICE
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (800) 859-5995 X3994.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Did the requestor provide a position statement with their request for MFDR?
2. Are the disputed services subject to the provisions of a certified workers' compensation health care network?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The health care provider failed to submit a position statement for review with the request for dispute resolution.

Rule 28 Texas Administrative Code §133.307(c)(2) requires the provider, when requesting MFDR, to include the following information and documents with the request:

(A) the name, address, and contact information of the requestor;

(B) the name of the injured employee;

(C) the date of the injury;

(D) the date(s) of the service(s) in dispute;

(E) the place of service;

(F) the treatment or service code(s) in dispute;

(G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;

(H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;

(I) the disputed amount for each treatment or service in dispute;

(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

(L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;

(M) a copy of all applicable medical records related to the dates of service in dispute;

(N) a position statement of the disputed issue(s) that shall include:

(i) the requestor's reasoning for why the disputed fees should be paid or refunded,

(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

(iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable …

(Q) any other documentation that the requestor deems applicable to the medical fee dispute.

DWC urges requestors to provide the above information and documents with any request for MFDR.

DWC rules provide, if the required information is not received, DWC may base its decisions on the information available at the time of review.

Providers may find the most current versions of Texas workers' compensation rules either directly from the DWC website at: https://www.tdi.texas.gov/wc/rules/index.html

Or from the Texas Secretary of State's website: https://texreg.sos.state.tx.us/public/tacctx$.startup

This decision is based on the information available at the time of review.

2. The respondent asserts, “Texas Mutual claim… and BAPTIST ST ANTHONYS HEALTH SYSTEM are participants in the WorkWell Network. (Attachment)… Because this is network healthcare Rule 133.307 does not apply.”

   Based on information maintained by Texas Department of Insurance, Division of Workers’ Compensation (DWC), the injured employee has not been enrolled in a certified workers’ compensation health care network (HCN) established in accordance with Texas Insurance Code Chapter 1305.

   Review of the documents submitted by the respondent found no information to support that the injured employee’s claim is subject to the provisions of a certified workers' compensation HCN established in accordance with Insurance Code Chapter 1305.

   The respondent provided documentation to support provider participation, but the submitted document did not show that the health care provider is contracted with or participates in the alleged WorkWell network.

   No information was provided to support that the health care provider was contracted directly with the carrier or with the alleged network. No information was provided to support the insurance carrier was authorized to access a contracted fee arrangement between the provider and any third party on the dates of service.

   Furthermore, Rule 28 Texas Administrative Code §133.240(f)(15) requires the paper form of any explanation of benefits (EOB) to include the “workers' compensation health care network name (if applicable);” however, the submitted EOBs do not mention the WorkWell network, or any network.

   To the contrary, the EOBs state, “Insurance carrier payment to the health care provider shall be according to Division medical policies and fee guidelines in effect on the date(s) of service(s).” Based on the submitted documentation, the insurance carrier failed to give notice to the health care provider that it was asserting the defense that reimbursement was subject to a network contract or fee arrangement.

   The respondent has failed to support the assertion that the disputed health care is subject to the provisions of a workers’ compensation HCN established in accordance with Texas Insurance Code Chapter 1305. Accordingly, reimbursement is determined consistent with DWC rules and fee guidelines.

   Moreover, 28 Texas Administrative Code §133.307(d)(2)(F) requires the carrier response to "address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The insurance carrier’s failure to give notice to the health care provider of specific codes or explanations for denial of payment as required by Rule 28 TAC §133.240 constitutes grounds for DWC to find a waiver of defenses during Medical Fee Dispute Resolution. And such a waiver is found in this case.

   The respondent raised new defenses in their position statement for which the carrier failed to give any notice to the health care provider during the bill review and reconsideration processes or before the filing of this MFDR request. Consequently, the insurance carrier has waived the right to raise such new defenses during MFDR. Any newly raised defenses or denial reasons will not be considered in this review.

3. This dispute regards outpatient hospital services with reimbursement subject to DWC’s *Hospital Facility Fee Guideline*, Rule 28 TAC §134.403.

   The insurance carrier denied the disputed services with claim adjustment reason codes:

   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 785 – SERVICE RENDERED IS INTEGRAL TO SERVICE REQUIRING PREAUTHORIZATION. PREAUTHORIZATION NOT SOUGHT/APPROVAL NOT OBTAINED FOR THAT SERVICE

   Rule 28 TAC §134.600(p)(2) requires preauthorization of non-emergency outpatient surgical services.

   The submitted records did not support a medical emergency; therefore, preauthorization was required.

   No information was presented to support that authorization had been obtained for the disputed services. The insurance carrier’s denial reasons are therefore supported. Consequently, payment cannot be recommended.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of the division is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above, the requestor failed to establish that additional payment is due. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 18, 2019
Signature	Medical Fee Dispute Resolution Officer	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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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