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
St Joseph Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0276-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted.

Amount in Dispute: $5,166.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual argues DWC MDR has no jurisdiction in this matter."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2019	Outpatient hospital services	$5,166.65	$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 Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
2. 28 Texas Administrative Code §133.305 outlines resolution of medical fee disputes.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 786 – Denied for lack of preauthorization denial in accordance with the network contract
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the insurance carrier's reason for denial of payment supported?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on July 17, 2019. The insurance carrier denied for lack of preauthorization of a network contract. The insurance carrier submitted evidence that the injured worker was enrolled in a workers' compensation certified network at the time of service. No position was submitted by the requestor.

   28 TAC §133.305 (a) (4) defines medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee.

   DWC 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.

   Based on the above DWC's 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 health care provider was authorized by the certified network to do so.

   DWC finds insufficient evidence to support an authorization was requested or obtained to perform the out of network services.

   As a result, the medical fee dispute is not eligible for medical fee dispute resolution review under 28 TAC §133.307.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC 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 has not established payment is due. As a result, the amount ordered is $0.00.

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

		November 21, 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 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.