



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

METSL, LLC

MFDR Tracking Number

M4-20-0750-01

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Date Received

November 22, 2019

Carrier's Austin Representative

Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note that services were approved as reasonable and necessary for date range of 3/7/19-5/8/19 which out of network approval was obtained under Authorization #... and documentations are enclosed for review. Please reprocess and remit payment for billed amount of \$2,508.00."

Amount in Dispute: \$2,508.00

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 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. Further, Texas Mutual has no evidence the requestor, a non-network provider, received an out-of-network approval to provide the service or treatment on 3/21/19."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
March 21, 2019	Outpatient Facility Charges	\$2,508.00	\$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307, sets out the procedures for resolving medical fee disputes
2. 28 Texas Insurance Code (TIC) Chapter 1305 applicable to Health Care Certified Networks.
3. 28 TAC §§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 Requestor obtain an out-of-network referral from the injured employee's treating doctor that was approved by the network pursuant to §1305.103?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 TAC §133.307?

Findings

1. The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 TAC (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply TLC statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the TIC, Chapter 1305. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §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 §1305.103."

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

TIC §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 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 TIC §1305.103.

The Division finds that the requestor failed to prove in this case that that the requirements of TIC §1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

The TDI rules at 28 TAC §§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 may be filed to the Texas Department of Insurance's (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 TIC Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks.

FINDINGS

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC §413.031, the Division has determined that the requestor is not eligible for Medical Fee Dispute Resolution under 28 TAC §133.307.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 19, 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 TAC §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 DW045M** 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 TAC §141.1(d).