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
METHODIST REHAB HOSPITAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-21-0200-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 9, 2020

Response Submitted By
Texas Mutual Insurance Company

REQUESTOR'S POSITION SUMMARY

"MRH obtained preapproval for services and provided services to patient.

- Although MRH and Mutual had not contracted to provide services to this patient, Texas Department of Insurance guidelines state that MRH is entitled to fair and reasonable compensation for its services.
- MRH maintains that under Medicare payment guidelines reimbursement for services provided to… would have been $477.62.
- $943.63 is halfway between total billed charges and what Medicare would pay. MRH believes that this is fair and reasonable compensation for services provided…"

RESPONDENT'S POSITION SUMMARY

"Texas Mutual claim… Texas Mutual reviewed its online Network provider directory for the requestor's name and for its tax identification number, and found no evidence MHS-CHC ILP is a participant in that Network… A copy of the preauth letter was submitted. After auditor applied the recommended reimbursement, the bill was denied by the bill review system as it was determined the Facility is an out of network provider. Denial modifier D27 was applied appropriately."

SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
February 19, 2020 through April 10, 2020	97112, 97140, 97161 and 95992	$1,409.65	$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 (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.

Issue

1. Did the requestor obtain approval from the certified network to treat the injured employee?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 TAC §133.307?

Findings

The requestor filed this medical fee dispute with the Division requesting resolution pursuant to 28 TAC §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply the Texas Labor Code (TLC) statutes and rules, including 28 TAC §133.307 and is limited to the conditions outlined in the applicable portions of the 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."

TIC §1305.006 (3) provides that, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee: (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."

TIC 1305.103 (e) provides that, "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."

The requestor therefore has the burden to prove that the condition(s) outlined in TIC §§1305.006 and 1305.103 were met in order to be eligible for dispute resolution. The following are the Division's findings.

1. The services in dispute were denied with reduction code(s) "D27 – Provider not approved to treat WorkWell. TX Network claimant." TIC Section 1305.006 requires, in pertinent part, that "(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 it obtained the appropriate approval/referral from the certified healthcare network for the out-of-network care it provided.

   The requestor, states, "MRH obtained preapproval for services and provided services to patient." Although, the requestor submitted a copy of a preauthorization letter for the treatment it rendered, no documentation was found to support that the requestor received the out of network referral to see the injured employee. The Division concludes that the requestor did not receive approval from the Certified Network to see the injured employee; thereby failing to meet the requirements of TIC §§1305.006(3) and 1305.103.

2. The requestor failed to prove in this case that that the requirements of TIC §§1305.006(3) and 1305.103 were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 TAC §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 TAC §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 29, 2020 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 **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 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).