



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

<u>Requestor Name</u> UT HEALTH TYLER	<u>MFDR Tracking Number</u> M4-21-1192-01
<u>Respondent Name</u> TEXAS MUTUAL INSURANCE COMPANY	<u>MFDR Date Received</u> March 16, 2021
	<u>Carrier's Austin Representative</u> Box Number 54

REQUESTOR'S POSITION SUMMARY

"This Request for Reconsideration of adjusted and/or disputed amounts is due to: 336 - DOS Not Paid. PROVIDER IS IN NETWORK WITH TEXAS STAR NETWORK."

RESPONDENT'S POSITION SUMMARY

"The requestor is disputing the denial made by Texas Mutual citing the carrier did not comply with payment for services rendered per Rule 134.403 and 134.404. The providers position statement confirms that services rendered were for outpatient hospital clinic services, therefore, Rule 134.404 is not applicable to this dispute. The provider submitted a request for reconsideration contesting the denial for Network status of the provider, however the EOB from Texas Mutual confirms the denial is for a preauthorization requirement. (see DWC60 pg. 19 & 20) Additionally, Texas Mutual reviewed the online Network Provider directory by the requestor's name and tax identification number and found no evidence that UTHEALTH Tyler is a network provider."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Ordered
August 24, 2020	Outpatient Services	\$734.92	\$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

- 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
- 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

Issue

- Did the requestor render services to an injured employee enrolled in a certified network?
- 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 DWC asking for resolution pursuant to 28 TAC (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the DWC 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 DWC’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 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 DWC concludes that the requestor thereby has failed to meet the requirements of TIC §1305.103.

The DWC 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 MFDR 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 DWC finds that the disputed may be filed to the TDI’s 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.

Conclusion

The Division finds that this dispute is not under the jurisdiction of the Division of Workers’ Compensation and is therefore, not eligible for medical fee dispute resolution under 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 Texas Administrative Code §133.307.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date
April 6, 2021

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 Texas Administrative Code §141.1(d).