



# 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 COMPANY

**MFDR Tracking Number**

M4-21-1686-01

**Carrier's Representative**

Box Number 54

**MDR Received Date**

March 24, 2021

**Response Submitted by:**

Texas Mutual Insurance Company

#### REQUESTOR'S POSITION SUMMARY

"...DOS Not Paid. Preauthorization was not obtained due to injury was emergent in nature. Please reprocess bill."

#### RESPONDENT'S POSITION SUMMARY

"Texas Mutual claim... is in the WorkWell Network... Texas Mutual Insurance argues if the surgery was elective and the provider indicates the patient had a choice of treatment options, then Dr. Mark Henry had time to request preauthorization for the procedure to be completed at St. Joseph's Medical Center."

#### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
December 15, 2020	Rev Code 250-710	\$639.45	\$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 (DWC).

#### Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.

#### Issues

1. Did the out-of-network healthcare provider meet the requirements of Chapter §1305.006?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

**Findings**

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

Texas Insurance Code (TIC) §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "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:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (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 §1305.153 (c) provides "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.

The Divisions 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 meets one of the conditions(s) outlined in TIC §1305.006.

The Division finds that the insurance carrier submitted sufficient documentation to support that the services in dispute were rendered by an out-of-network provider to an in-network injured employee. Insufficient documentation was submitted by the requestor to support that the condition(s) outlined in TIC §1305.006 (1) were met. Adjudicating the disputed service would involve enforcing a law, regulation, or other provision for the disputed service(s), provided to an in-network injured employee. The Division finds the disputed services are not under the jurisdiction of the Division of Workers' Compensation and therefore, are not eligible for medical fee dispute resolution under 28 TAC §133.307.

The Division finds that the disputed services were rendered to an in-network injured employee. 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 services may be filed to the 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 and may be the appropriate administrative remedy to address matters related to health care certified networks.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered. 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.

**ORDER**

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

\_\_\_\_\_  
June 18, 2021  
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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 DWC. **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).