



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

OAKBEND MEDICAL CENTER

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-21-2401-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 24, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2020	97112, 97110, 97530 and 97164	\$5,092.00	\$0.00
Total		\$5,092.00	\$0.00

Requester's Position

"...In summary... fell at work suffering multiple injuries that resulted in.... She required physical therapy for vestibular therapy to help relieve her symptoms and improve her functional abilities. We are respectfully requesting your approval of this medically necessary physical therapy and look forward to a favorable response to this dispute resolution request."

Amount in Dispute: \$5,092.00

Respondent's Position

"Texas Mutual claim [claim number] is in the WorkWell Network. The facility did not obtain preauthorization for services rendered per Rule 134.600. Healthcare providers can refer to network preauthorization requirements... Texas Mutual has no record of receiving a preauthorization request for Physical therapy. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applies to health care certified networks.

Denial Reasons

The insurance carrier reduced or denied the payment of the disputed services with the following claim adjustment codes:

- 197 – Precertification/authorization/notification absent.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

Issues

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

Findings

1. 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 TAC §133.307.

Texas Insurance Code §1305.106 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 §1305.153 (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."

The Division finds that the requestor did not obtain preauthorization for the treatment in dispute. As a result, the disputed services are not eligible for medical fee dispute resolution. The Division finds that 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 Texas Administrative Code §133.307.

The Division finds that the disputed services were rendered to an in-network injured employee. The TDI rules at 28 Texas Administrative Code §§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 Texas Insurance Code 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 Texas Administrative Code §133.307.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not eligible for resolution under 28 TAC §133.307.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 28, 2021
Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option 3, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefieres hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.