



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requester Name**

CASA VIEW CHIROPRACTIC CLINIC

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-0520-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

November 12, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 31, 2021 through September 17, 2021	98941, G0283, 97024, 97012 and 97110	\$1,532.00	\$0.00
<b>Total</b>		\$1,532.00	\$0.00

### Requester's Position

"Texas Mutual sent a workers' compensation referral to Casa View Chiropractic to seek treatment... August 31, 2021-September 17, 2021, we never received payment... Texas Mutual then sent a letter stating were not covering the treatment bills. After speaking with Texas Mutual we were told that they are deciding if this is a work-related injury. At this time, we are sending this to MFDR to see if you can help us receive payment for these days of treatment."

**Amount in Dispute:** \$1,532.00

### Respondent's Position

"Texas Mutual is the benefits administrator for claim... and determined this claim is in the Texas Star Network. Chiropractor Jeff Vining rendered Physical Therapy and Chiropractic Manipulations to the claimant. No evidence was submitted with the DWC60 that the provider attempted to obtain preauthorization, nor was treatment certified per network requirements."

**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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applies to health care certified networks.

## Denial Reason(s)

The insurance carrier reduced or denied payment for the services in dispute with the following claim adjustment code(s):

- CAC-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 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 submitted insufficient documentation to support that preauthorization was obtained for the treatment rendered on August 31, 2021 through September 17, 2021. 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 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 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 outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been 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**

It is ordered that this dispute is not eligible for resolution under 28 TAC §133.307.

### **Authorized Signature**

_____	_____	December 3, 2021
Signature	Medical Fee Dispute Resolution Officer	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](http://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](mailto: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.