TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
SOUTH TEXAS RADIOLOGY IMAGING

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-1429-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 14, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 12, 2021	72146	$363.50	$0.00
	Total	$363.50	$0.00

Requester's Position

"STRIC POSITION: Texas Mutual denied our claim for no authorization. We sent an appeal to say we verified with the Texas Mutual rep no authorization was required. Our reconsideration request was denied. Please help us with final adjudication of this bill for date of service 11/12/2021..."

Amount in Dispute: $363.50

Respondent's Position

"Texas Mutual claim [claim number] is in the Texas Star Network... Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

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 precertification 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 obtained an out-of-network referral, however, did not obtain preauthorization for the treatment rendered on November 12, 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

		April 14, 2022
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. 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 prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.