TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SPINE & JOINT CLINIC

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 7, 2011

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-12-0434

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Attached you will find Designated Doctor Report stating compensable injury also Carrier's letter stating: carrier accepts [injury] and [injury] as a compensable diagnosis... Please process our bills and sent payment..."

Amount in Dispute: $1,555.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...attached is the Atty rep form showing WQ Thai Nguyen as the treating. Then it shows Patel, DC starting to treat on 1/12/11. No referral is mentioned in the notes. Since Dr. Patel is a DC, he would not have been authorized to treat. Dr. Nguyen is not in the carrier network either."

Response Submitted by: Flahive, Ogden & Latson

DISPUTED SERVICES SUMMARY

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
January 13, 2011 through January 26, 2011	99204, 99080-73, EO-215, 97140, 97112 and 97110	$1,555.90	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 28 Texas Administrative Code §133.305 sets out the procedure for Medical Fee Dispute Resolution.
4. 28 Texas Administrative Code §141.1 sets out the procedures for Requesting and Setting a Benefit Review Conference.

Issue

1. Does the medical fee dispute referenced above contain information/documentation to support that the disputed date(s) of service(s) January 13, 2011 through January 26, 2011 contains an unresolved extent-of-injury issue?
2. Did the requestor meet the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 to file for medical fee dispute resolution?
3. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?
4. Does TDI address the submission of a complaint by a health care provider to the Health Care Network?

Findings

1. The requestor seeks resolution for CPT Code(s) 99204, 99080-73, EO-215, 97140, 97112 and 97110 rendered on January 13, 2011 through January 26, 2011. Review of the submitted documentation finds that the medical fee dispute referenced above contains an unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process. The insurance carrier denied/reduced the disputed service(s) with denial reason code(s), "851 – Payment Disallowed. Entitlement to benefits not finally adjudicated' and "W11-Entitlement to benefits. Not finally adjudicated."

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. The Division finds that the dispute contains an unresolved extent-of-injury issue for this dispute. As a result, the dispute is not eligible for review.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The Division hereby notifies the requestor that the appropriate process to resolve the extent-of-injury issue may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

2. The requestor filed for medical fee dispute with 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 apply Texas Labor Code statues and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, 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."

   Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(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."

   Texas Insurance Code Section 1305.103 requires, in pertinent part, 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 Division notified the requestor in August 2013 that the disputed services were provided to an injured employee enrolled in a certified network. The notification letter contained information outlining the dispute path for in-network providers and out-of-network providers. The authority for MFDR to resolve matters involving employees enrolled in a certified health care network is conditional. The requestor therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution.

3. The requestor has the burden to prove that it obtained the appropriate approval from the certified network for the out-of-network care it provided. The Division finds that the requestor submitted insufficient documentation to support that that an out-of-network referral was obtained pursuant to Section 1305.103, thereby failing to meet the requirements of Texas Insurance Code Section 1305.006(3). Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

4. The Division finds that the disputed services were rendered by an out-of-network healthcare provider 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 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 may be the appropriate administrative remedy to address fee matters related to 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 Texas Administrative Code §133.307.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 4, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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