



# 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**

SHANNON MEDICAL CENTER

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

December 1, 2011

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**MFDR Tracking Number**

M4-12-1026

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We respectfully ask that you reprocess this admit at 90% of Medicare allowable per the Texas fee schedule."

**Amount in Dispute:** \$6,328.90

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This dispute involves a fee reimbursement dispute between a network provider, the requestor, and Texas Mutual for services provided on a Network claim... The proper venue for the requestor is through the complaint process with Coventry Workers' Complainant Services. Information on that process was afforded to the requestor upon entry as Network provider."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 29, 2011 through July 30, 2011	Outpatient Facility Charges	\$6,328.90	\$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**

- 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code §133.307, sets out the procedures for resolving a medical fee dispute.
- Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
- 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.

#### **Issues**

- Did the in-network healthcare provider render services to an in-network injured employee?
- Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §§133.305 and 133.307?
- Does 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?

**Findings**

1. The requestor billed for Outpatient Facility Charges rendered on July 29, 2011 through July 30, 2011 to an injured employee enrolled in a certified healthcare network. The insurance carrier’s response indicates that both the healthcare provider and the injured employee are enrolled in a certified healthcare network. The requestor seeks a decision from the Division’s medical fee dispute resolution (MFDR) section.
2. 28 Texas Administrative Code §133.305 (a) (4) defines a medical fee dispute as “A dispute that involves an amount of payment for **non-network** health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is resolved by the Division pursuant to Division rules, including §133.307 of this subchapter (relating to MDR of Fee Disputes).” Non-network health care is defined in Section (a) (6) of the same rule as “Health care not delivered, or arranged by a certified workers compensation health care network as defined in Insurance Code Chapter 1305 and related rules...”  
 Per 28 Texas Administrative Code §133.307 (a) (3) “...In resolving **non-network** disputes which are over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.” Adjudicating the fees for the disputed services would involve enforcing a law, regulation, or other provision related to the price of the disputed service(s), provided by an in-network health care provider 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.
3. The Division finds that the disputed services were rendered by an in-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 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 may be the appropriate administrative remedy to address fee 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. This decision is based upon a review of all the evidence presented by the parties in this dispute. 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***

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**

Signature	Medical Fee Dispute Resolution Officer	Date
		July 15, 2016

***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.**