



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON ORTHOPEDIC & SPINE HOSPITAL

Respondent Name

WAUSAU BUSINESS INSURANCE CO

MFDR Date Received

APRIL 6, 2012

Carrier's Austin Representative

Box Number 01

MFDR Tracking Number

M4-12-2545

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual failed to pay surgery CPT Codes at 100% 2nd at 50% our contract states 90% of APC rate will be the paid amount."

Amount in Dispute: \$4,392.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on April 10, 2012. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2011	Hospital Outpatient Services	\$4,392.47	\$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 §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
3. 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

1. Did the in-network healthcare provider render services to an in-network injured employee?
2. Is the requestor eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.305?
3. What may be the appropriate administrative remedy to address fee matters related to health care certified networks?

Findings

1. The requestor seeks a decision from the division's medical fee dispute resolution (MFDR) section. The authority for MFDR to resolve matters involving employees enrolled in a certified health care network is

conditional. 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 that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes.” The Division defines non-network health care in paragraph (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 ...” That is, the Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider was authorized by the certified network to do so.

2. The Division notified the requestor that the disputed services were provided to an injured employee enrolled in a certified network. The requestor was provided with information/documentation outlining the dispute path for in-network healthcare providers and out-of-network healthcare providers. Review of the documentation in this dispute supports that the health care provider treated an injured employee enrolled in a certified network. The requestor did not submit a response and/or submitted insufficient documentation to the Division to support that the disputed services are eligible for review by Medical Fee Dispute Resolution section. The division concludes that the services in dispute are not eligible for review pursuant to 28 Texas Administrative Code §133.305.
3. 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 rendered by an in-network healthcare facility to an in-network injured employee may be filed to the Texas Department of Insurance's (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 not all the evidence was 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 §133.305.

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

April 21, 2015

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.