



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

ROC HOUSTON

Carrier's Austin Representative

Box Number 05

MFDR Date Received

June 29, 2012

Respondent Name

STANDARD FIRE INSURANCE CO

MFDR Tracking Number

M4-12-3253-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our understanding that benefits were significantly reduced due to your determination that the billed charges are more than the usual and customary rate for certain procedures or items. Surgery reimbursement rates are typically adjusted based on the TX DWC fee schedule per 28 TAC 134.402. However, the payment rendered does not appear to be comparable with the TX DWC rates charges for this service and no information was been given to support your position that the denial is correct."

Amount in Dispute: \$1,063.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim is enrolled in the Carrier's Certified Healthcare Network, and the Provider is contracted with the Carrier's HCN. The Claimant's employer enrolled in the HCN prior to the Claimant's date of injury, and the Claimant's injury is covered by the HCN."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2012	11012, 13132, 26765 and 99223	\$1,063.10	\$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 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.

The insurance carrier’s response indicates that both the healthcare provider and the injured employee are enrolled in a certified healthcare network. 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.

2. 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	November 6, 2014 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).