



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

HAND & WRIST CENTER
OF HOUSTON

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number

M4-22-2055-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 16, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 5, 2021	29130	\$114.07	\$0.00
August 5, 2021	73140	\$90.89	\$0.00
TOTAL		\$204.96	\$0.00

Requester's Position

"The healthcare provider's position on this claim is that the services have been underpaid. We find that none of the services billed on the claim were paid at 100% of the statutory fee as required by law... Additionally, we cannot attach explanation of benefits (EOB) from the carrier as it was never filed to the Workers compensation insurance and only to the employer."

Amount in Dispute: \$204.96

Respondent's Position

"This claim is in the WorkWell, TX network. Texas Mutual has reviewed the network provider directory for the provider's name and tax identification number and confirmed no record of HAND & WRIST CENTER OF HOUSTON DEPT A as a participant. As an out-of-network provider, approval is required before rendering service or treatment. Texas Mutual did not receive or find any evidence of out-of-network approval obtained by the requestor... Since this fee reimbursement dispute involves a network requirement under the Insurance Code rather than the Labor Code, Texas Mutual believes this dispute is outside the jurisdiction of DWC MDR. Our position is that no payment is due."

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 (TIC) [Chapter 1305](#) governs workers' compensation health care networks.

Denial Reason(s)

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment code(s):

- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18 – Exact duplicate claim/service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 243 – Services not authorized by network/primary care providers.
- DC4 – No additional reimbursement allowed after reconsideration.
- DC7 – Duplicate appeal. Network contract applied by WorkWell, TX Network.
- D27 – Provider not approved to treat WorkWell, TX Network Claimant.

Issues

1. Are the disputed services out-of-network health care?
2. If the disputed services are out of network, is the insurance carrier liable for the disputed services under TIC §1305.006?

Findings

1. The requestor, Hand & Wrist Center of Houston, submitted medical fee dispute M4-22-2055-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns post-surgical medical care provided by the requestor on August 5, 2021. Per the submitted documentation, the injured employee's claim is within the WorkWell, TX certified network. The requestor was not in the network at the time of the date of services in dispute. As a result, DWC finds that the requestor provided out-of-network health care to the injured employee.

A medical fee dispute of this nature is within the jurisdiction of DWC.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of the TIC, Chapter 1305, are applicable to DWC's ability to apply the TLC legislation and DWC rules for out-of-network health care. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §1305.006 titled *INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE* states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (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 §1305.103."

The requestor has the burden to prove that the conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services.

DWC finds that the requestor failed to provide any documentation to support that any of the conditions of TIC §1305.006 were met in this dispute. As a result, DWC finds that the insurance carrier is not liable for the out-of-network health care in dispute.

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. DWC concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	April 25, 2024
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, call CompConnection at 1-800-252- 7031, Option three, 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.