TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

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
M4-23-0714-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 21, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2021	20680, 73140, and 99080-73	$3,512.13	$0.00
	Total	$3,512.13	$0.00

Requester's Position

"The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

Amount in Dispute: $3,512.13

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
3. 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):

- D27 – Provider not approved to treat WorkWell, TX Network Claimant.
- 243 – Services not authorized by network/primary care providers.
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 18 – Exact duplicate claim/service.
- 248 - DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per Rule 129.5.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.
- DC7 – Duplicate appeal. Network contract applied WorkWell, TX network.
- 350 – In accordance with TDI-DWC rule 134.804. This bill has been identified as a request for reconsideration or appeal.

Issues

1. Are the disputed services out-of-network health care?
2. Has the requestor waived their right to medical fee dispute resolution?

Findings

1. The requestor, Hand & Wrist Center of Houston, submitted medical fee dispute M4-23-0714-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns post-surgical follow-up medical care provided by the requestor on November 15, 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 service in dispute. As a result, the requestor provided out-of-network health care to the injured employee.

   The Requestor, having provided out-of-network services, asserts that the care provided was "emergency care" such that network-based restrictions are inapplicable, and the respondent/ carrier is required to pay in accordance with the TLC and DWC rules. A medical fee dispute of this nature is within the jurisdiction of DWC.

2. The requestor seeks payment for medical services provided in an office setting.

   28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

   The service in question was performed on November 15, 2021. On November 21, 2022, the Division received the request for medical dispute resolution. This date is more than a year following the in-question date(s) of service.

   28 TAC §133.307 (c) (1) (A) states, "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   A review of the submitted documentation finds that the disputed service does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requestor has failed to timely file this dispute with the DWC; consequently, the requestor has waived the right to medical fee dispute resolution.

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 10, 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, please 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.