



## 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**

M4-23-1946-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

April 6, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 3, 2022	97110-GO, and 97140-GO	\$162.41	\$0.00
<b>Total</b>		\$162.41	\$0.00

### Requester's Position

"The healthcare provider's position on this claim is that this date of service has been partially denied. We find that one of the charges on this claim has not been paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. 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:** \$162.41

## Respondent's Position

"This dispute of service was submitted as a non-network dispute, however, the Texas Mutual claim [claim number] and HAND & WRIST CENTER OF HOUSTON DEPT A are both participants in the WorkWell, TX Network.

Texas Mutual's WorkWell, TX network, a Texas Department of Insurance approved entity, provides service to claims that occur after January 1, 2018. Texas Mutual partners with Align to provide credentialing and contracting function for Physical medicine/Rehabilitation services. This means there are providers in the WorkWell, TX network that are either contracted through Texas Mutual or Align.

The A12 modifier denial code instructs the provider to send their bills to Align for the services rendered.

In this dispute, Align provided the contracting function for WorkWell, TX with HAND & WRIST CENTER OF HOUSTON DEPT A even though HAND & WRIST CENTER OF HOUSTON DEPT A is in the WorkWell, TX network only for Align contracted services (physical and/or occupational therapy services). This explains why there is reference to Align on Texas Mutual's Explanation of Benefits (EOB) found in the requestor's DWC-60 packet and on the screenshot from the WorkWell, TX provider directory."

**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.
3. Texas Labor Code (TLC) Sections [413.011](#) (d-1) to (d-6) [expired] and 413.0115, as well as former division Rule at 28 TAC §[133.4](#) sets out certain provisions related to informal and voluntary insurance networks.
4. TLC §[413.031](#) entitles health care providers to a review of services if payment is reduced.

## **Denial Reason(s)**

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

- A12 – CALL 877-269-9373. SERVICES BILLED BY AN ALIGN PROVIDER. PER CONTRACT, THE PROVIDER MUST BILL ALIGN. NO AUTH ON FILE TO BILL TEXAS MUTUAL.
- CAC-W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-18 – EXACT DUPLICATE CLAIM/SERVICE.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (888) 532-5246.
- DC7 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY WORKWELL, TX NETWORK. CALL (888) 532-5246 FOR RECONSIDERATION DISCUSSION.
- 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.

## **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, and Wrist Center of Houston submitted medical fee dispute M4-23-1946-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns postoperative physical therapy services provided by the requestor on November 3, 2022. Per the submitted documentation, the injured employee's claim is within the WorkWell Certified Healthcare Network.

The insurance carrier states in pertinent part, "...there are providers in the WorkWell, TX network that are either contracted through Texas Mutual or Align. In this dispute, Align

provided the contracting function for WorkWell, TX with HAND & WRIST CENTER OF HOUSTON DEPT A even though HAND & WRIST CENTER OF HOUSTON DEPT A is in the WorkWell, TX Network.”

The requestor seeks reimbursement for a therapeutic exercise session and manual therapy technique, billed under CPT codes 97110-GO and 97140-GO, rendered on November 3, 2022.

Per TLC §413.011(d-1) to (d-6) and §413.0115, as well as 28 TAC §133.4, other than for certain pharmacy, durable medical equipment, or home health care services, insurance carriers may not contract with informal or voluntary insurance networks to provide workers’ compensation services effective January 1, 2011, unless such a former informal or voluntary network was certified as a workers’ compensation health care network under Chapter 1305, Insurance Code, no later than January 1, 2011.

Further, the injured employee must be enrolled in the certified workers’ compensation network and the certified workers’ compensation network must be named on the explanation of benefits, per 28 TAC §133.240(f)(15). Based on the information provided by Texas Mutual Insurance Company, the injured employee is enrolled in the WorkWell network certified in accordance with Texas Insurance Code Chapter 1305.

28 TAC §133.240(f)(15) requires that the insurance carrier shall include the “workers’ compensation health care network name (if applicable)” on the paper form of an explanation of benefits. While the explanation of benefits does mention “Align”, it is not a specific workers’ compensation healthcare network registered with the Texas Department of Insurance, as a certified Texas workers’ compensation health care network established in accordance with Insurance Code Chapter 1305.

The respondent did not submit any information regarding a contract between the insurance carrier and the Align certified workers’ compensation health care network. Nor did it present any information to support the health care provider, is contracted with such a network. Accordingly, based on the information presented to MFDR, the division finds that the insurance carrier has failed to support that a contractual or network agreement applies to the services in this dispute.

Based on the information presented by the respondent for review, the division concludes the respondent has failed to support that the healthcare provider is enrolled in the WorkWell certified healthcare network, and/or that a valid contract exists between the “Align” network and the requestor. The respondent did however submit sufficient documentation to support that the injured employee is enrolled in the WorkWell, a certified worker’s compensation HCN.

The requestor was not in the WorkWell network at the time the date of service was rendered. 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 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 therefore has the burden to prove that the exceptions outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor contends that the disputed services were provided for emergency care in TIC §1305.006(1). TIC §1305.006(2) and (3) were not shown to be applicable in this case.

DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were emergency care. TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care provided on the dates of service were emergency care under TIC §1305.006. Furthermore, for the dates of service at issue, the documentation provided was not sufficient to show that the care provided was for a medical emergency as defined in TIC §1305.004(13). Because the treatment for these dates of service was not shown to be emergency care, the insurance carrier is not liable for this non-network care under TIC §1305.006.

## **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

_____	_____	May 8, 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](http://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](mailto: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.