



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baylor Orthopedic & Spine Hospital

Respondent Name

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-23-2225-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

May 8, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2022	29879	\$5,629.07	\$0.00
Total		\$5,629.07	\$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated May 2, 2023 that states, "Per EOB received bill denied for provider out of network. Please note that out of network approval was obtained under Authorization# 5757012 for date range 9/21/2022-11/20/2022, and proof of authorization enclosed for review."

Amount in Dispute: \$5,629.07

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 BAYLOR ORTHO AND SPINE HOSPITAL 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. Section 1305.103(e) of the Insurance Code states 'A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network.'"

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 Chapter 1305](#) applies to health care certified networks.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- Note: When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 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.
- D27 – Provider not approved to treat WorkWell claimant.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Is the respondent's denial supported?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services render on September 23, 2022. The insurance carrier denied the services as not authorized by network.

The Division of Workers' Compensation has the authority to resolve cases involving workers who are enrolled in a certified health care network, subject to the restrictions specified in the relevant sections of Chapter 1305 of the Texas Insurance Code (TIC) and the restricted application of statutes and rules of the Texas Labor Code, such as 28 TAC §133.307.

Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307 and sections of TIC, Chapter 1305, are applicable to the DWC's ability to apply the TLC statutes and DWC rules for out-of-network health care.

TIC §1305.153 (c) states 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 which addresses 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 and 1305.103 were met for the insurance carrier to be liable for the disputed services. In their attempt to support the disputed services were approved by the network, the requestor included a "Texas Mutual WorkWell, TX" out-of-network approval dated September 26, 2022. Review of this document found the approval effective date is 9/26/2022. The date of service in dispute is 9/23/2022.

DWC finds that the requestor failed to provide 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 finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 05, 2024
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 3 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 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.