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

**Requestor Name**
Texas Health Alliance

**Respondent Name**
LM Insurance Company

**MFDR Tracking Number**
M4-24-0186-01

**Carrier's Austin Representative**
Box Number 60

**DWC Date Received**
September 6, 2023

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| April 8, 2023 | Outpatient Facility Charges | $743.16 | $0.00 |
| | **Total** | $743.16 | $0.00 |

## Requestor's Position

"We are in receipt of a payment of $0.00, however this claim was underpaid by $743.16. Our calculations are based on the Medicare outpatient rates for CPT code 99284, which is $743.16 and the outpatient work comp multiplier is 200% without separate implant reimbursement per rule 134.403, see below), and the total work comp fee schedule allowance is $743.16, and finally, deducting the payment $0.00, leaves an unpaid balance due of $743.16."

**Amount in Dispute:** $743.16

## Respondent's Position

**"**In accordance with Chapter 28 TAC §10.121, an investigation has been completed on your issue. The bill was reviewed and denied correctly as the provider does not have a contract with Liberty HCN and the provider did not receive out of network approval by the Claims Case Manager. Attached is print out from our Provider Referral Services Site showing the TIN is not found as participating."

**Response Submitted by:** Liberty Mutual Insurance Company

# Findings

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance (TDI), 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. 28 TAC §§10.120 through 10.122 address the submission of a compliant by a health care provider to the Health Care Network.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 5884 – Provider is not within the Liberty Health Care Network for this customer. Insurance code 1305.004(B) and Labor Code 401.011.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the out-of-network healthcare provider render services to an in-network injured worker?
2. Under what conditions is the insurance carrier liable for out-of-network healthcare?
3. Is the insurance carrier liable for the disputed services?

Findings

1. The requestor submitted this dispute seeking reimbursement in accordance with 28 TAC §133.307. The dispute concerns outpatient services provided by the requestor on April 8, 2023.

   A review of the documentation and information known to the DWC finds that the injured workers' claim is within a certified healthcare network. The requestor, an out-of-network provider, rendered services to an in-network injured worker.

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 the 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 DWC concludes that the requestor failed to produce sufficient proof that the services were provided in the event of an emergency, that the location was outside of its service area, or that it had received an out-of-network referral for the treatment of the injured worker.

Upon reviewing the documentation, it has been determined that the requestor did not provide sufficient evidence to substantiate any of the exceptions in §1305.006 were met, as a result, the requestor is not eligible for medical fee dispute resolution.

3. In order for the insurance carrier to be held liable for the disputed services, the requestor must demonstrate that the condition or conditions listed in TIC §1305.006 were met. The requestor has not provided enough evidence to demonstrate that any of the requirements listed in TIC §1305.006 were met.

   DWC concludes that the insurance company is not responsible for the disputed out-of-network services.

**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. The Division 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 that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | March 13, 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.