



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Peak Integrated Healthcare

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-24-0993-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

January 9, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 3, 2023	E0730	\$167.38	\$0.00
Total		\$167.38	\$0.00

Requestor's Position

"The Texas Administrative Code Rule 134.600(P)(12)-any SINGLE ITEM durable medical equipment (DME) under \$500 -does NOT require pre-authorization or peer to peer reviews."

Amount in Dispute: \$167.38

Respondent's Position

"This claim is in the Texas Star Network network and the health care service(s) rendered require preauthorization per Rule 134.600. The TENS unit is a stimulation device and does require preauthorization[sic]. Texas Mutual has no record that the provider obtained preauthorization. The health care provider attempted to obtain preauthorization; however, they are out of network, and it was denied."

Response Submitted by: Texas 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:

- CAC-W3& 350 – IN ACCORDANCE WITH TDI-DWC RULE 134,804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION. FOR INFORMATION CALL (888) 532-5248.
- 786 – DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.

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 a DME service provided by the requestor on July 3, 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, to qualify for a review of the disputed services.

3. The requestor therefore has the burden to prove that the condition(s) outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor has submitted insufficient documentation to prove that any of the conditions outlined in TIC §1305.006 applied to the disputed services.

DWC concludes that the requestor failed to demonstrate 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 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. 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 the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

March 22, 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 prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.