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
Baylor Surgical Hospital

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-24-1397-01

Carrier's Austin Representative
Box Number 60

MFDR Date Received
February 26, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 25, 2023	29823	$5,796.87	$0.00
	Total	$5,796.87	$0.00

Requester's Position

The requestor did not submit a position statement with this request for MFDR. Rather, they submitted a document titled "Reconsideration" that states, "Per EOB received bill denied due to provider out of network. Please note that authorization was obtained and approved for treatment under Review# 264079 with date range 09/08/2023-11/07/2023, and proof of authorization enclosed for review."

Amount in Dispute: $5,796.87

Respondent's Position

"This letter acknowledges receipt of your Network (HCN) complaint on March 5, 2024."

Supplemental response dated March 20, 2024

"Attached is print out from our Provider Referral Services Site showing the TIN is not found as participating. I have also attached a copy of the letter from Utilization Management advising 'In order to receive payment, any provider or facility who delivers services associated with this preauthorization request must be a member of the Liberty Health Care Network or a member of the certified network in which the employer participates, unless prior approval to involve out-of-network providers or facilities has been granted.'"

Response Submitted by: Liberty Mutual Insurance

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 Reason(s)

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

- 16 – Claim/service lacks information which is needed for adjudication.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5732 – Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s). Health care providers shall not bill any unpaid amount to the injured employee or the employer or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code 408.024. However, pursuant to 133.250 of the Title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 5884 – Provider is not within the Liberty Health Care Network (HCN) for this customer. Insurance Code (illegible) and Labor Code 401.011.

Issues

1. Was the preauthorization for out of network care?
2. Is this dispute eligible for medical fee dispute resolution under 28 TAC §133.307?
3. What may be the dispute path for resolving issues pertaining to in-network healthcare?

Findings

1. The requestor claims they received prior authorization for the disputed services. A review of the submitted Review #264079 states specifically, "In order to receive payment, any provider or facility who deliver services associated with this preauthorization request must be a member of the Liberty Health Care Network…" Insufficient evidence was found to support whether the requestor is a member of the Liberty Health Care Network or that an out-of-network authorization was obtained.

2. The requestor filed this medical fee dispute to the DWC requesting reimbursement for the disputed services, governed by the for resolution pursuant to 28 TAC §133.307 titled *MDR of Fee Disputes*. 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.

   The authority of the Division of Workers' Compensation, to resolve matters involving employees enrolled in a certified health care network is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 TAC §133.307.

   Texas Insurance Code §1305.106 provides that "An insurance carrier that establishes or contracts with a network is liable for the following **out-of-network** health care that is provided to an injured employee... (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 Section 1305.103."

   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 has the burden of proving that the condition(s) outlined in TIC §§1305.006 and 1305.103 were met to be eligible for dispute resolution. The requestor presented insufficient proof and/or documentation to support that it obtained the appropriate approval/referral from the certified healthcare network for the out-of-network health care it provided. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 TAC §133.307.

3. The DWC finds that the disputed services were rendered to an in-network injured employee. The TDI rules at 28 TAC §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The DWC finds that the disputed services may be filed to the TDI Complaint Resolution Process if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 and may be the appropriate administrative remedy to address matters related to health care certified networks.

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 DWC finds 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	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 512-804-4812.