



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**

Mason Physical Therapy & Wellness

**Respondent Name**

Texas Mutual Insurance Co.

**MFDR Tracking Number**

M4-24-2495-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 10, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 1, 2023, through January 10, 2024	CPT Codes 97112, 97110, 97140	\$742.00	\$0.00

### Requestor's Position

The submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

**Amount in Dispute:** \$742.00

### Respondent's Position

"This claim is in the WorkWell, TX network and the health care service(s) rendered require preauthorization per Rule 134.600. Texas Mutual has no record that the provider obtained preauthorization."

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

## Findings and Decision

### **Authority**

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §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.

### **Denial Reasons**

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

- 197 - PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
- 786 - DENIED FOR LACK OF PREAUTHORIZATION OR PREAUTHORIZATION DENIAL IN ACCORDANCE WITH THE NETWORK CONTRACT.
- 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.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION, FOR INFORMATION CALL (888) 632-5246.
- 350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

### **Issues**

1. Are the disputed services out-of-network health care?
2. Under what conditions is the insurance carrier liable for out-of-network health care?
3. Is the insurance carrier liable for the disputed services?

### **Findings**

1. The requestor, Mason Physical Therapy & Wellness, submitted a medical fee dispute, tracking number M4-24-2495-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns outpatient therapy services provided by the requestor on December 1, 2023, through January 10, 2024. Per the submitted documentation and from information known to the division, the injured employee's claim is within the WorkWell network. The requestor is not within the WorkWell network. As a result, the requestor provided out-of-network health care to the injured employee.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code statutes and Texas Administrative Code rules, including 28 TAC §133.307. The requirements mentioned in the relevant 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."
3. The requestor has the burden to prove that the conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services.

DWC finds that the requestor failed to provide any 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. 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, DWC hereby determines the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	_____	July 24, 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 1-800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).