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
HAND & WRIST CENTER OF HOUSTON

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-25-0450-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 25, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2024	99080-73	$15.00	$0.00
March 18, 2024	73130	$92.78	$0.00
March 18, 2024	20680	$5,109.36	$0.00
	Total	$5,217.14	$0.00

Requester's Position

"The healthcare provider's position on this claim is that this date of service has been partially denied. We find that one of the charges on this claim has not been paid at 100% of the statutory fee as required by law per Texas Administrative Code Title 28 Part 2 Chapter 134 Subchapter C Rule 134.202. The attached medical records adequately support each of the services provided and is sufficient to warrant payment as set forth by the aforementioned section of the Texas Administrative Code. The injured worker's medical condition has been determined to be a medical emergency as defined in the Texas Administrative Code."

Amount in Dispute: $5,217.14

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 HAND & WRIST CENTER OF HOUSTON as a participant. The attached shows the HAND & WRIST CENTER OF HOUSTON is contracted only for physical and occupational therapy, treatment rendered does not fall under these categories. 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."

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 (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reason(s)

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 243 – Services not authorized by network/primary care providers.
- D27 – Provider not approved to treat WorkWell, TX Network Claimant.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- W3, 350 – 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.
- 248 - DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per rule 129.5.

- 18 – Exact duplicate claim/service.
- DC7– Duplicate appeal. Network contract applied by WorkWell, TX network.

Issues

1. Are the disputed services out-of-network health care?

2. If the disputed services are out of network, is the insurance carrier liable for the disputed services under TIC §1305.006?

Findings

1. The requestor, Hand & Wrist Center of Houston, submitted medical fee dispute M4-25-0450-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns unpaid services provided by the requestor on March 18, 2024. Per the submitted documentation, the injured employee's claim is within the WorkWell, TX certified network. The requestor was not in the network at the time of the date of service in dispute. As a result, the requestor provided out-of-network health care to the injured employee.

   The Requestor, having provided out-of-network services, asserts that the care provided was "emergency care" such that network-based restrictions are inapplicable, and the respondent carrier is required to pay in accordance with the TLC and DWC rules. A medical fee dispute of this nature is within the jurisdiction of DWC.

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 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 requestor therefore has the burden to prove that the exceptions outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor contends that the disputed services were provided for emergency care in TIC §1305.006(1). TIC

§1305.006(2) and (3) were not shown to be applicable in this case.

DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were emergency care. TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care provided on the date of service was emergency care under TIC §1305.006. Furthermore, for the date of service at issue, the documentation provided was not sufficient to show that the care provided was for a medical emergency as defined in TIC §1305.004(13). Because the treatment for this date of service was not shown to be emergency care, the insurance carrier is not liable for this non-network care under TIC §1305.006.

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 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

		November 14, 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.