TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Methodist Dallas Medical Center

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-25-1031-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 11, 2024	Rev. Code 0361, CPT code 11042	$728.32	$0.00

Requester's Position

"Requesting review of unpaid procedure."

Amount in Dispute: $728.32

Respondents' Position

"This claim is in the Texas Star Network and the health care service(s) rendered require preauthorization per Rule 134.600. Texas Mutual has no record that the provider obtained preauthorization. Health care providers can refer to network preauthorization requirements at texasmutual.com/provider-preauth. In addition, the facility provided documentation which states the patient present for a follow up visit for wound care. The provider's assessment indicated that the patient feels well with no problems other than the [redacted], please refer to page 9 of the DWC-60 packet. Therefore, the documentation does not support an emergency."

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. 28 TAC §124.2 set out the Insurance Carrier Notification Requirements.
3. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reason(s)

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

- CAC-219 – The treatment or service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
- CAC-197 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
- CAC-219 – Based on extent of injury.
- W3 – 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.
- DC4 – No additional reimbursement allowed after reconsideration.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

Issues

1. Are there any unresolved issues of the extent of injury?
2. Are the disputed services out-of-network health care?
3. If the disputed services are out of network, is the insurance carrier liable for the disputed services under TIC §1305.006?

Findings

1. The insurance carrier denied payment with claim adjustment reason code 219 – "Based on extent of injury."

   Rule §124.2(h) requires notification to the division and claimant of any dispute of disability or extent of injury using plain language notices with language and content prescribed by the division. Such notices "shall provide a full and complete statement describing the carrier's action and rationale" for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim."

   Rule §133.307(d)(2)(H) further requires that if the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with Rule §124.2 (relating to carrier reporting and notification requirements). The respondent did not submit copies of any PLN-11 or plain language notices issued in accordance with Rule §124.2, as required by Rule $133.307(d)(2)(H). The carrier has failed to meet the requirements of Rule §133.307(d)(2)(H) regarding any issues of extent of injury and has waived the right to raise such issues.

   Based on the submitted information, denial reason code 219 is not supported. The division concludes there are no unresolved issues of the extent of injury. Consequently, the disputed services are eligible for medical fee dispute resolution review.

2. The requestor, Methodist Dallas Medical Center, submitted medical fee dispute M4-25-1031-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns the facility charge billed under CPT code 11042 provided by the requestor on March 11, 2024. Per the submitted documentation and from information known to DWC, the injured employee's claim is within the Texas Star Network. The requestor was not in the network at the time of the date of service, as a result, the requestor provided out-of-network health care to the injured employee.

3. 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 any of the exceptions outlined in the TIC §1305.006 were met, for the insurance carrier to be liable for the disputed services. TIC §1305.006(1), (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 date of service in dispute met any of the exceptions in TIC §1305.006 (1), (2), and (3). 28 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 met any of the exceptions in TIC §1305.006. Because the treatment for this date of service was not shown to meet any of the exceptions in TIC §1305.006, the insurance carrier is not liable for this non-network care.

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 the Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		April 10, 2025
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.