



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requester Name**

Beaumont Bone & Joint  
Institute

**Respondent Name**

Jefferson County

**MFDR Tracking Number**

M4-25-2029-01

**Carrier's Austin Representative**

Box Number 29

**MFDR Date Received**

April 29, 2025

### Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due    |
|------------------|-------------------|-------------------|---------------|
| July 30, 2024    | 99205             | \$425.00          | \$0.00        |
| July 30, 2024    | 73130             | \$26.00           | \$0.00        |
| <b>Total</b>     |                   | <b>\$451.00</b>   | <b>\$0.00</b> |

### Requester's Position

"Our records indicate that patient's adjustor Mrs. Tiffany Black provided us with patient claim information and authorized us to see (injured worker). Therefore, I called Mrs. Black on 08/28/24 regarding such denial. She explained that we are out of network and (injured worker) was aware of it, in fact she had provided him with an in-network provider list and had advised him to choose care from one of those providers, but (injured worker) insisted on seeing Dr. Jones and was scheduled for date of service 07/30/24."

**Amount in Dispute:** \$451.00

### Respondent's Position

"Following a comprehensive review of the claim and accompanying documentation, payment is not recommended. Services were not authorized by the network or rendered by a network primary care provider."

**Response Submitted by:** Injury Management Organization, Inc.

## **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):

- 243 – Services not authorized by network/primary care providers.

### **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, Beaumont Bone and Joint Institute, submitted a medical fee dispute, tracking number M4-25-2029-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns professional medical services provided by the requestor on July 30, 2024. Per the submitted documentation and from information known to the division, the injured employee's claim is within the IMO Med-Select Network. The requestor is not within the IMO Med-Select 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, the DWC hereby determines the requestor is entitled to \$0.00 reimbursement for the services in dispute.

**Authorized Signature**

|           |  |               |
|-----------|--|---------------|
| _____     | _____                                  | June 11, 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](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).