TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Texas Schools Property & Casualty

MFDR Tracking Number
M4-11-3055

Carrier's Austin Representative
Box Number 44

MFDR Date Received
February 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 08/27/2010 I performed an evaluation to determine maximum medical improvement and impairment of the … claimant. I performed this examination at the request of the injured employee and the treating doctor…

I am an independent evaluator with no network affiliations as to maintain non-bias opinion. This procedure does not require pre authorization."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Dr. Trenton D. Weeks is not part of the Certified Workers' Compensation Health Care Network, First Health, Managed Care Orgainzation. Since this MMI exam was at the request of the treating doctor the claimant (a) should have been referred to a provider participating in the certified network (b) Authorization should have been requested from the Carrier."

Response Submitted by: JI Specialty Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2010	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$350.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 governs the procedures for Certified Health Care Networks.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 38 – Services not provided or authorized by designated (network/primary care) providers.
   - Notes: "DR WEEKS IS NOT ON NETWORK, NO TREATMENT ALLOWED BY HIM"
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based no this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What are the circumstances that give the Division the authority to review a medical fee dispute involving a network claim?
2. Was network authorization required for the disputed service?
3. Did the requestor obtain network authorization in accordance with Texas Insurance Code §1305.103?
4. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

2. Texas Insurance Code §1305.006 states 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:
   > (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 Section 1305.103.

   The requestor, therefore, must meet the conditions outlined in the Texas Insurance Code §1305.006 to be eligible for dispute resolution. Submitted documentation does not support that the disputed services were provided as emergency care or that the injured employee does not live within the service area of any network established by the insurance carrier. Texas Insurance Code §1305.103(e) stipulates that:

   > A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

   Submitted documentation supports that the requestor was an out-of-network referral doctor. Therefore, the disputed services required network authorization.

3. Review of the submitted documentation does not support that the network approved the out-of-network referral to the requestor. Therefore, the Division concludes that the requestor did not obtain network authorization in accordance with Texas Insurance Code §1305.103.

4. The Division finds that the conditions of Texas Insurance Code §1305.006 were not met. For this reason, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	December 4, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.