Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAPTIST ST ANTHONY'S HEALTH

Respondent Name
SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Date Received
October 31, 2012

MFDR Tracking Number
M4-13-0602-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility was notified by the office of the treating physician, Dustin Frazier, M.D., that these services were preauthorized at our facility under authorization #795578761 issued by CorVel "

Amount in Dispute: $7,278.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This hospital was not enrolled in any known carrier-related network on the date of service. The claimant is enrolled in a Certified HealthCare Network. Therefore, all medical treatment must be provided within the Texas CoreCare Certified Network. However, the Requestor is not enrolled in the Texas CoreCare Certified Network ... Respondent seeks a finding that Requestor is due no reimbursement as the Requestor failed to obtain approval to treat Claimant out of network."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Austin, Tx 78735

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
February 7, 2012	Outpatient Hospital Services	$7,278.91	$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307, 37 TexReg 3833, applicable to medical fee disputes filed on or after June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks
3. The services in dispute were denied by the respondent with reason code 196 *Non Network Provider*

FINDINGS AND DECISION

Issue

1. Did Baptist St Anthony's Health receive approval from the Texas CoreCare Network to treat the injured employee?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

Baptist St Anthony's Health filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes.* The authority of the Division of Workers' Compensation to apply Texas Labor Code statues 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." Baptist St Anthony's Health therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution of the facility services provided. The following are the Division's findings.

1. The services in dispute were denied due to "196 Non-Network Provider." Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(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, Baptist St Anthony's Health, has the burden to prove that it obtained the appropriate approval from Texas CoreCare Certified Network for the out-of-network care it provided. The requestor, Baptist St Anthony's Health, in its request for reconsideration dated April 24, 2012 states "Our facility was notified...that these services were preauthorized at our facility under authorization #795578761...We were not aware of any network affiliation." Authorization numbered 795578761 states "Approval Hardware removal...the requesting physician and facility are not in network and therefore this request may be denied. The claimant must treat with a Texas CoreCare Network physician and facility, please call 1-866-353-9768 if you need further network assistance." Although a letter dated January 12, 2012 supports that the surgeon Dustin Frazier, M D received approval from the Texas CoreCare Certified Network to treat the injured employee, no documentation was found to support that Baptist St Anthony's Health received its own, separate approval from Texas CoreCare Certified Network to treat the injured employee at its location. The Division concludes that Baptist St Anthony's Health did not receive approval from the Texas Core Care Network to treat the injured employee; thereby failing to meet the requirements of Texas Insurance Code Section 1305.006(3).

2. The requestor Baptist St Anthony's Health failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature

Martha P Luevano
Medical Fee Dispute Resolution Manager

April 21, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).