



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

FONDREN ORTHOPEDIC GROUP

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

January 15, 2013

**Respondent Name**

LM INSURANCE CORP

**MFDR Tracking Number**

M4-13-1196-01

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Claim was processed and denied stating provider not within the HCN for patient. Prior to seeing the patient authorization was obtained for the visit and DME. Auth # is 121280244S001001. We are respectfully requesting you reprocess this claim and pay accordingly."

**Amount in Dispute:** \$150.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The injury of [date of injury] for [injured employee] is included in the Liberty [sic] HCN however, the provider Barry Raborn at your facility, Fondren Orthopdic [sic] Group does not participate in the Network. We have no record of a request of preauthorization from the Network for treatment outside the Network by Dr. Raborn and no record that the Network gave authorization for out of Network treatment by this provider."."

**Response Submitted by:** Liberty Mutual Insurance

**DISPUTED SERVICES SUMMARY**

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
May 15, 2012	L3001	\$150.00	\$0.00

**BACKGROUND**

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

**FINDINGS AND DECISION**

**Issue**

1. Did the requestor receive a referral approval from the certified 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**

The requestor 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 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." The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

1. 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."

Texas Insurance Code Section 1305.103 requires that "(e) 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."

The requestor has the burden to prove that it obtained the appropriate network approved referral for the out-of-network care it provided. The requestor, in its request for reconsideration dated August 1, 2012 states, "Claim was processed and denied stating provider not within the HCN for patient. Prior to seeing the patient authorization was obtained for the visit and DME. Auth # is 121280244S001001. We are respectfully requesting you reprocess this claim and pay accordingly." The Division finds that although the requestor obtained preauthorization from the network for the treatment in dispute (Auth # is 121280244S001001), the requestor failed to submit documentation to support that a referral was obtained pursuant to TIC Section 1305.103.

2. The Division finds that the requestor 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

\_\_\_\_\_  
Medical Fee Dispute Resolution Manager

**October 30, 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, **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 file 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).