



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name

TEXAS IMPAIRMENT EXAM/TRENTON D WEEKS DC
 PO BOX 3947
 GRAPEVINE TX 76099

MFDR Tracking Number

M4-13-1723

MFDR Date Received

MARCH 7, 2013

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative

Box Number 54

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 10/02/2012 I performed an evaluation to determine maximum medical improvement and impairment of the above named claimant. I performed this examination at the request of the injured employee and the treating doctor..."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim is in Texas Mutual's Texas Star Network (Network). There is no evidence that the out-of-network service was approved by the Network. The requestor conducted an examination of the claimant on 10/02/2012. This claim is in the Network. The requestor is not a participating health care provider in the Network nor does he claim to be. The requestor cites in his position statement Texas Labor Code provisions that apply to designated doctors. However, Dr. Trenton Weeks, the doctor who performed the examination, did not perform the examination as a designated doctor or an RME doctor. Accordingly, his arguments related to non-network affiliation and requirements to pay designated doctors do not apply in this case. Because there is no evidence presented of approval of the out-of-network referral, Texas Mutual is not liable for payment."

Response Submitted by: Texas Mutual Insurance Company

DISPUTED SERVICES SUMMARY

| Date(s) of Service | Disputed Service(s) | Amount In Dispute | Amount Ordered |
|--------------------|-----------------------|-------------------|----------------|
| October 2, 2012 | Professional Services | \$650.00 | \$0.00 |

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

Issue

1. Did the Requestor obtain an out-of-network referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103?
2. 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 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."

Texas Insurance Code Section 1305.006 states, in pertinent part, "(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 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.

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."

2. The requestor has the burden to prove that it obtained the appropriate approved out-of-network referral for the out-of-network healthcare it provided. Review of the submitted documentation finds that the requestor submitted insufficient documentation and/or no documentation to support that a referral was obtained from the treating doctor and approved by the network to treat the injured employee. The Division concludes that the requestor thereby has failed to meet the requirements of Texas Insurance Code Section 1305.103.

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

September 17, 2015
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).