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
TEXAS MIDWEST SURGERY CENTER

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 17, 2014

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-14-3157-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr Clifford DePrang's office obtained authorization for the surgeon and Texas Midwest Surgery Center from Liberty Mutual utilization management department on 8/25/2013. On the attached authorization you will see that the authorization setting is for outpatient and that Liberty Mutual carbon copied Texas Midwest Surgery Center on page 2 of the letter. Liberty mutual is denying this claim as they state Texas Midwest Surgery Center is not in their network."

Amount in Dispute: $20,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on 06/24/2014. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint. You rise will be forwarded to the appropriate department for further handling. They will investigate the matter and provide you with a written response within thirty (30) day of receipt of your complaint."

Response Submitted by: Liberty Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
August 21, 2013	29807, 29823, 29827 and 29826	$20,000.00	$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 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." The requestor 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. 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." The requestor has the burden to prove that it obtained the appropriate referral from the injured employee's treating doctor that has been approved by the network for the out-of-network care it provided.

   The requestor, in its position summary states, "Dr Clifford DePrang's office obtained authorization for the surgeon and Texas Midwest Surgery Center from Liberty Mutual utilization management department on 8/25/2013. On the attached authorization you will see that the authorization setting is for outpatient and that Liberty Mutual carbon copied Texas Midwest Surgery Center on page 2 of the letter. Liberty mutual is denying this claim as they state Texas Midwest Surgery Center is not in their network." Transaction Code 132140302S001 001 states "...authorized only as stated...Arthroscopy, shoulder, surgical; repair of slap lesion... In order to receive payment, any provider or facility who delivers services associated with this preauthorization request must be a member of the Liberty Health Care Network unless prior approval to involve out-of-network providers or facility has been granted."

   Although a letter dated, August 5, 2013 supports that the surgeon Clifford L DePrang received preauthorization from the certified network to treat the injured employee, no documentation was found to support that the requestor obtained a referral from the treating doctor that has been approved by the network. The Division concludes that the requestor did not receive a referral approval from the Network to treat the injured employee, thereby failing to meet the requirements of Texas Insurance Code Section 1305.103.
2. 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

		October 30, 2014
Signature	Medical Fee Dispute Resolution Manager	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).