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
FOUNDATION SURGICAL HOSPITAL SAN ANTONIO

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 29, 2014

Respondent Name
LM INSURANCE CORP

MFDR Tracking Number
M4-15-0782-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On July 22, 2014 we requested that Liberty Mutual reconsider the bill and issue reimbursement to the Hospital for the medically necessary services provided, but that was also denied for lack of authorization because the Hospital was not within the Liberty Mutual Network, and allegedly no out of network referral was provided. However, it is clear from the Hospital's notes that the procedure was approved for the 'facility of choice', thus appropriate authorization was given and the Hospital is entitled to reimbursement."

Amount in Dispute: $52,627.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a network claim but the provider is not participating in the Liberty HCN. The dispute is being addressed as a network complaint and a complete response will be completed and a resolution letter will be provided within 30 days of receipt."

Response Submitted by: Liberty Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
May 13 2014 through May 14, 2014	Outpatient facility charges	$52,627.19	$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 an out-of-network 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 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, 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.

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 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

Signature	Medical Fee Dispute Resolution Officer	November 20, 2014 Date
Signature	Medical Fee Dispute Resolution Manager	November 20, 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).