



**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**

MEDSPRING URGENTCARE

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

January 30, 2015

**Respondent Name**

LIBERTY MUTUAL INSURANCE CORP

**MFDR Tracking Number**

M4-15-1630-01

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I understand that we are not in-network, but request that these at least be considered for payment at an out of network rate, as we continue to try to become a member of the Texas Star Network [sic]." ."

**Amount in Dispute:** \$365.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on March 13, 2015. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint. Your issue 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) days of the receipt of your complaint."

**Response Submitted by:** Liberty Mutual Insurance Company

**DISPUTED SERVICES SUMMARY**

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
April 16, 2014	99214, 99080-69 and 99080-73	\$365.00	\$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 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 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.

- 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

\_\_\_\_\_  
March 26, 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).