



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Gregory P. Ennis, M.D.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-3473-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 18, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "On July 16, 2015 EcCare workers' compensation specialist ... did contact Texas Mutual via telephonic means and spoke with one Desiree Richard adjuster of record, who did give verbal permission to proceed with the examination by referral of the treating doctor, George S. Walls, M.D. Said conversation was noted on the treating doctor's referral form enclosed."

**Amount in Dispute:** \$650.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual claim ... is in the Texas Star Network. ... Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its tax identification number listed on the bill ... and found no evidence **ECCARE PROFESSIONAL ASSN OF TEXAS PA** is a participant in that Network under that tax ID number."

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

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	\$650.00	\$0.00

#### FINDINGS AND DECISION

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

**Background**

- 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical disputes.
- 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.

1. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

### **Issues**

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 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.

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. The division finds that the great weight of evidence fails to support that the referral obtained from the treating doctor for the services in question was approved by the network to treat the injured employee. 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.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

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 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

August 22, 2016  
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, 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 MFDR 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).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**