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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert C. Lowry, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-18-2033-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 12, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was requested to perform a MMI/IR exam on the above named claimant, via a referral from the treating doctor. In that referral, I was also asked to opine on extent of injury."

Amount in Dispute: $1,300.00

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, and found no evidence **ROBERT C LOWRY LLC** is a participant in that Network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 6, 2017	Referral Examination to Determine Maximum Medical Improvement, Impairment Rating, and Extent of Injury	$1,300.00	$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

1. 28 Texas Administrative Code §133.307 – MDR of Fee Disputes
2. Texas Insurance Code, Chapter 1305 - Workers' Compensation Health Care Networks
3. Texas Labor Code §401.011 – General Definitions
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - CAC-243 – Services not authorized by network/primary care providers.
    - 727 – Provider not approved to treat Texas Star Network claimant.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issues

1. Is the claim in question part of a workers' compensation health care network?
2. Was approval for out-of-network care obtained for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. Robert C. Lowry, M.D. filed this medical fee dispute to the division asking for resolution under 28 Texas Administrative Code (TAC) §133.307. The authority of the Division of Workers' Compensation to apply Texas Labor Code (TLC) statutes and rules, including 28 TAC §133.307, to claims that are part of a workers' compensation health care network is limited to the conditions outlined in the applicable portions of Texas Insurance Code (TIC), Chapter 1305.

   Documentation submitted to the division supports that the injured employee's claim involved in this dispute was part of a workers' compensation health care network – Texas Star Network.

2. In this case, Dr. Lowry confirms that he is not a member of the Texas Star Network. Treating doctors are required to make referrals to providers within the network for health care,[1] which includes medical evaluations.[2] If a network provider is not available, approval is required from the network for the referral.[3]

   If an out-of-network provider has received a referral from the treating doctor and has been approved by the network, then the provider is reimbursed under the Texas Workers' Compensation Act and related rules.[4]

   Dr. Lowry has the burden to prove that he received approval from the network for the disputed medical evaluation. Dr. Lowry failed to provide evidence to meet this burden.

3. Because Dr. Lowry did not support his eligibility for reimbursement of the services in question, the division determines that no reimbursement is recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	September 12, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] TIC §1305.103(e)
[2] TIC §1305.004; TLC §401.011
[3] TIC §1305.103(e)
[4] TIC §1305.153(c); TIC §1305.006(3)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.