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
Baptist St Anthony's Hospital

MFDR Tracking Number
M4-20-0104-01

MFDR Date Received
September 16, 2019

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted

Amount in Dispute: $136.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…this is a network claim."

Response Submitted by: Flahive, Ogden and Latson

DISPUTED SERVICES SUMMARY

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
November 6 – 29, 2018	Physical therapy services	$136.65	$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 obtain an out-of-network referral from the injured employee's treating doctor that was approved by the network pursuant to Section 1305.103?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed this medical fee dispute asking for resolution pursuant to 28 TAC §133.307.

   Review of the submitted documentation found the injured worker is enrolled in a certified network and the insurance carrier applied a network reduction based on the First Coventry Network.

   The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules. 28 TAC §133.307 limits the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 particularly TIC §1305.153 (c) which in pertinent part states health care provided by an out-of-network provider is pursuant to a referral from the injured employee's treating doctor that has been approved by the network shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

   The requestor 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 DWC findings.

2. Review of the submitted documentation finds 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 thus the requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006 described above.

   Consequently, the services in dispute are not eligible for medical fee dispute resolution.

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

		January 10, 2020
Signature	Medical Fee Dispute Resolution Officer	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 DWC, within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).