



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

MHHS HERMANN HOSPITAL

MFDR Tracking Number

M4-20-0715-01

MFDR Date Received

November 18, 2019

Respondent Name

BITCO NATIONAL INSURANCE CO

Carrier's Austin Representative

Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a for a services provided by Memorial Hermann Hospital for a workers comp injury for the above named patient. As of right now, clam [sic] denied stating no Authorization, however Authorization was obtained on 12/19/2018."

Amount in Dispute: \$80,423.03

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant is in the Texas CorCare Network. Moreover, the provider, Memorial Hermann Hospital knows that the claimant is in a certified health care network; and they, Memorial Hospital also knows that it is not in the Network. Accordingly, the provider knows that he is not entitled to any reimbursement unless the treatment involves emergency care or the claimant does not live within the service area of the network or the provider has received a referral from the injured employee's treating doctor that has been approved by the network."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2018 to December 21, 2018	Inpatient Hospital Service	\$80,423.03	\$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 §133.305, 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.

Issues

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 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."

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."

2. 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.

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

		December 20, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

Signature

Martha Luévano
Director of Medical Fee Dispute Resolution

December 20, 2019
Date

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.