TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
BURRIS, BENJAMIN S.

**Respondent Name**
NETHERLANDS INSURANCE CO

**MFDR Tracking Number**
M4-20-2163-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
May 4, 2020

## *REQUESTOR'S POSITION SUMMARY*

**"REFERRAL FOR THIS SERVICE: NO NETWORK REQUIREMENT AND NO PREAUTHORIZATION**: This service was referred by the examinee's treating doctor for purpose of Maximum Medical Improvement and Impairment Rating and billed accordingly … In this case, the provider on this claim is certified and meets all of the DWC requirements. The certifying doctor IS NOT required by rule to be part of the same healthcare network as the treating doctor. There is additionally no requirement for pre-authorization for this type of service."

**Amount in Dispute:** $650.00

## *RESPONDENT'S POSITION SUMMARY*

"This is an HCN claim. The Provider, Genesis, is an out-of-HCN seeking reimbursement as a referral physician. Liberty did not authorize the referral per section 1305.103(e) of the Texas Insurance Code, and in fact expressly denied it on September 5, 2019. The referring provider, Advantage, is also out-of-HCN. And as such, it *cannot* be a treating doctor as contemplated by sections 1305.103 and 1305.104 of the Texas Insurance Code, and it *cannot* make referrals to other out-of-HCN providers."

**Response Submitted by:** Liberty Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 17, 2019 | Examination to Determine Maximum Medical Improvement and 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 (DWC).

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.1 sets out the requirements for certification of maximum medical

improvement and impairment rating.
3. 28 Texas Insurance Code (TIC) Chapter 1305 applicable to Health Care Certified Networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Claim/service denied because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 5819 – Not treating doctor.

**Issues**

Are the insurance carrier's reasons for denial of payment supported?

**Findings**

Benjamin S. Burris, M.D. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. Dr. Burris argued that this examination "was referred by the examinee's treating doctor." A doctor may be authorized to perform this examination when referred by the treating doctor.[1]

Liberty Mutual Insurance, on behalf of the insurance carrier, indicated that the claim in question is part of a certified health care network. The submitted explanation of benefits dated January 17, 2020 denied payment, in part, because Dr. Burris was not the treating doctor. In its position statement, Liberty Mutual Insurance stated that neither the requestor nor the referring doctor was in the claim's certified health care network.

Because the examination in question was not ordered by the DWC, the authority of the DWC is limited by the network rules in 28 TIC, Chapter 1305.[2] The network rules require that the treating doctor must provide health care to the injured worker 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**.[3]

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. Bills submitted with the request for medical fee dispute resolution indicated that the referral came from Priscilla Carroll, FNP. Dr. Burris presented no evidence that he was referred to perform this examination by the treating doctor on this network claim or that he received authorization from the network to perform the examination.

The TDI rules at 28 TAC §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The complaint process outlined in TIC Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to health care certified networks. The DWC finds that the disputed service may be filed to the TDI's Complaint Resolution Process if Dr. Burris is not satisfied with the outcome of the network complaint process.

**Conclusion**

For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

[1] 28 TAC §130.1 (a)(1)(A)(i)
[2] 28 TAC §133.307; 28 TIC §1305.006
[3] 28 TIC §1305.006; 28 TIC §1305.103

**Authorized Signature**

| | | |
|---|---|---|
| | | June 18, 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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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**.