TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Charles W. Hebert, D.C.

Respondent Name
Indemnity Insurance Co. of North

MFDR Tracking Number
M4-24-0345-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 10, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2023	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456-WP	$500.00	$500.00

Requestor's Position

"Approval WAS requested and received prior to exam."

Amount in Dispute: $500.00

Respondent's Position

"CorVel maintains the Requestor, Charles Wayne Hebert, is not entitled to reimbursement for date of service 07/19/2023 in the amount of $500 based on failure to obtain out-of-network approval from the Texas CorCare Network prior to services being rendered in accordance with TIC Sec. 1305.103(e) …

"The in-network Treating Doctor is required by rule and contract to request Out Of Network approval when a referral provider is not in the network. The TD is required to reach out to the network to find eligible providers. The Requestor is indicating that approval was given by the adjuster; however, adjusters cannot approve providers for OON. As per rule, only the network can provide approval …

"Although the injured worker reference above is an in-network employee the Requestor, Charles Wayne Hebert, is not. To date, CorVel has no record of an out-of-network request from the network Treating Doctor, Dr. Walls or Dr. Hebert for approval by the CorVel Texas CorCare Network for out-of-network health care."

Response Submitted by: CorVel

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

3. Texas Insurance Code (TIC), Chapter 1305 sets out the requirements for certified health care networks.

Denial Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- 242 – Services not provided by network/primary care prov
- NNP – Out-of-network approval not requested prior to rendering services
- Notes: "Per the Labor Code: 401.011(19) 'Health care' includes all reasonable and necessary medical aid, MEDICAL EXAMS, medical treatments, medical diagnoses, MEDICAL EVALUATIONS, and medical svcs. This is a medical evaluation. Claim is covered by TX CorCare HCN."
- Notes: "Per Sec 1305.006(3) a carrier is liable for out-of-network healthcare ONLY if the non-network HCP was referred from the IE's treating doctor AND that referral has been APPROVED by the network pursuant to Sec 1305.103. No OON approval submitted."
- Notes: "THERE WAS NO OUT OF NETWORK APPROVAL GIVEN BY THE ADJUSTER (ADJUSTERS CANNOT PROVIDE OUT OF NETWORK APPROVAL). THE QUESTIONS ASKED WERE REGARDING COMPENSABILITY, DISPUTES AND PREVIOUS IRs. TO DATE, NO OUT OF NETWORK APPROVAL REQUESTED"

Issues

1. Is the insurance carrier's denial based on network status supported?

2. Is Charles W. Hebert, D.C. entitled to reimbursement for the services in question?

Findings

1. The requestor, Dr. Hebert, submitted this medical fee dispute to DWC for resolution according to 28 TAC §133.307. The dispute concerns examination to determine maximum medical improvement and impairment rating as referred by the treating doctor and performed by the requestor on July 19, 2023. The insurance carrier denied payment stating that the services were not provided by network or primary care provider.

   Per 28 TAC §§133.305 and 133.307, medical fee dispute resolution by DWC is limited to non-network and certain out-of-network health care. DWC finds that the insurance carrier failed to provide documentation to support that the claim in question was part of a certified health care network as outlined in the applicable portions of TIC, Chapter 1305.

   DWC finds that the insurance carrier's denial of payment is not supported.

2. Because the insurance carrier failed to support its denial of payment for the services in question, Dr. Hebert is entitled to reimbursement.

   The submitted documentation supports the statement that Dr. Hebert performed an evaluation of maximum medical improvement. 28 TAC §134.250(3)(C) states that the maximum allowable reimbursement (MAR) for this examination is $350.00.

   Review of the submitted documentation finds that Dr. Hebert performed an impairment rating evaluation of the spine. The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is $150.00.

   The total allowable reimbursement for the services in question is $500.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that reimbursement of $500.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Indemnity Insurance Co. of North must remit to Charles W. Hebert, D.C. $500.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 8, 2023 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.