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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CHANNEL VIEW MEDICAL CENTER

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 24, 2008

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-09-1692-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the E.O.B. dated July 16, 2008 related to the date of service May 02, 2008. According to this E.O.B. all procedures were paid at zero (-0-) payment. The reason for the denial was 'this charge has been reimbursed according to the fee schedule or usual and customary value.' The DWC fee guideline allows $196.06 and $15.00 for the procedural code 99204 and 99080 respectively."

Amount in Dispute: $194.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges in dispute were denied because this claim is included in the Healthcare Network but the provider is not part of the Network."

Response Submitted by: Liberty Mutual Insurance

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
May 2, 2008	99204 and 99080-73	$194.08	$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307, 37 TexReg 3833, applicable to medical fee disputes filed on or after June 1, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

Dispute History for Medical Fee Dispute: M4-09-1692-01

- The dispute was originally decided on March 17, 2011.
- The original dispute decision was withdrawn by the Division's medical fee dispute resolution section on March 24, 2011.
- Because of the remand request, the dispute was re-docketed at the Division's medical fee dispute resolution section.
- M4-09-1692-02 is hereby reviewed.

FINDINGS AND DECISION

Issue

1. Did the requestor meet the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 to file for medical fee dispute resolution?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

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 to apply Texas Labor Code statues 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." The requestor therefore has the burden to prove that the condition(s) outlined in Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution of the facility services provided. The following are the Division's findings.

1. Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(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."

   Texas Insurance Code Section 1305.103 requires, in pertinent part, 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 requestor has the burden to prove that it obtained the appropriate approval from the certified network for the out-of-network care it provided. The Division finds that no documentation was submitted to support that the requestor obtained an out of network referral from the treating doctor authorized by the certified network, thereby failing to meet the requirements of Texas Insurance Code Section 1305.103(e).
2. 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

Signature	Medical Fee Dispute Resolution Officer	November 6, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.