



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

SELECT ANESTHESIA SERVICES

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 8, 2012

Respondent Name

BITCO GENERAL INSURANCE CORP

MFDR Tracking Number

M4-12-2331-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Anesthesia not required to be in-network."

Amount in Dispute: \$172.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed service was a spinal injection and not an ancillary charge to another primary procedure or service. Accordingly, network provider status or out-of-network treatment approval was required prior to the procedure. Carrier maintains that no reimbursement is owed for these out-of-network charges."

Response Submitted by: Flahive, Ogden & Latson

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
November 4, 2011	62310	\$172.71	\$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

FINDINGS AND DECISION

Issue

1. Did the requestor receive a referral approval from the certified network to treat the injured employee?
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 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." 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.

- 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 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."

The requestor has the burden to prove that it obtained the appropriate network approved referral for the out-of-network care it provided. The requestor, in its position summary states "Anesthesia is not required to be in-network." The Division concludes that the requestor did not receive a referral approval from the Network to treat the injured employee, thereby failing to meet the requirements of Texas Insurance Code Section 1305.103.

- 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 Manager

October 30, 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 prefriere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.