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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY IMAGING CENTERS

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MAY 24, 2012

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-12-2979

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...we respectfully request payment per the Texas Workers' Compensation Act."

Amount in Dispute: $626.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The MRI charges for date of service 12/13/11 are denied as out of Network provider. Our records indicate Dr. James Gilley of South Texas Radiology Imaging Center does not participate in the Liberty Mutual Health Care Network."

Response Submitted by: Liberty Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
December 13, 2011	73721	$626.99	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

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.

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?
3. Does TDI address the submission of a complaint by a health care provider to the Health Care Network?

Findings

1. The requestor filed for medical fee dispute with 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."

   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 Division notified the requestor on June 26, 2012 that the disputed services were provided to an injured employee enrolled in a certified network. The notification letter contained information outlining the dispute path for in-network providers and out-of-network providers. The authority for MFDR to resolve matters involving employees enrolled in a certified health care network is conditional. 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.
2. 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 the requestor submitted insufficient documentation to support that that an out-of-network referral was obtained pursuant to Section 1305.103, thereby failing to meet the requirements of Texas Insurance Code Section 1305.006(3). Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.
3. The Division finds that the disputed services were rendered by an out-of-network healthcare provider to an in-network injured employee. The TDI rules at 28 Texas Administrative Code §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network. The disputed services may be filed to the TDI Complaint Resolution Process, if the health care provider or facility is dissatisfied with the outcome of the network complaint process. The complaint process outlined in Texas Insurance Code Subchapter I, §1305.401 - §1305.405 may be the appropriate administrative remedy to address fee matters related to certified networks.

Conclusion

The Division finds that this dispute is not under the jurisdiction of the Division of Workers' Compensation and is therefore not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 8, 2016
Signature	Medical Fee Dispute Resolution Officer	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.