



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requestor Name**

VHS Brownsville Hospital

**Respondent Name**

Space Exploration Technologies Corp.

**MFDR Tracking Number**

M4-23-2622-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 13, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2023	72148	\$422.96	\$0.00

### Requestor's Position

"...the expected reimbursement amount is \$418.73. We have received payment in the amount of \$00.00... We are requesting an additional \$418. 73... This claim was been denied error, please review and remit balance that is udue."

**Amount in Dispute:** \$422.96

### Respondent's Position

"CorVel maintains the requestor, VHS Brownsville Hospital, is not entitled to reimbursement for date of service 01/19/2023 in the amount of \$7893.00 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). Although the injured worker referenced above is an in-network employee, the Requestor is not contracted with CorVel as a certified network provider. To date CorVel has no record of an out-of-network request from the network treating doctor or the Requestor (as required under Sec. 1305.103 above) for approval by the CorVel Texas CorCare Network for out of-network health care prior to services being rendered."

**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. [Texas Insurance Code \(TIC\) Chapter 1305](#) governs workers' compensation health care networks.

## **Denial Reasons**

The insurance carrier denied the payment for the disputed services with the following claim adjustment code(s):

- 242 – Services not provided by network/primary care provider.
- W3 – Appeal/Reconsideration
- NNP – Out-of-network approval not requested prior to rendering services.
- Explanation of Benefits Note: This claim is part of the Corvel Texas Healthcare Network (TXHCN).

## **Issues**

1. Are the disputed services out-of-network health care?
2. Under what conditions is the insurance carrier liable for out-of-network health care?
3. Is the insurance carrier liable for the disputed services?

## **Findings**

1. The requestor, VHS Brownsville Hospital, submitted a medical fee dispute, tracking number M4-23-2622-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns outpatient medical imaging services provided by the requestor on January 19, 2023. Per the submitted documentation and from information known to the division, the injured employee's claim is within the Corvel Texas Healthcare Network. The requestor is not within the Corvel Texas Healthcare Network. As a result, the requestor provided out-of-network health care to the injured employee.
2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code statutes and Texas Administrative Code rules, including 28

TAC §133.307. The requirements mentioned in the relevant sections of TIC, Chapter 1305, are applicable to the DWC's ability to apply the TLC statutes and DWC rules for out-of-network health care. TIC §1305.153 (c) states that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §1305.006 which addresses insurance carrier liability for out-of-network health care, states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (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 §1305.103."

- 3. The requestor has the burden to prove that the conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services.

DWC finds that the requestor failed to provide any documentation to support that any of the conditions of TIC §1305.006 were met in this dispute. As a result, DWC finds that the insurance carrier is not liable for the out-of-network health care in dispute.

**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. The Division concludes that the insurance carrier is not liable for the disputed services.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

August 6, 2024  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).