



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Charles W. Hebert, D.C.

Respondent Name

AIU Insurance Co.

MFDR Tracking Number

M4-24-2587-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2024	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456-WP	\$1,100.00	\$0.00

Requestor's Position

"All correspondence was to Sedgwick. Approval to conduct the MMI/IR exam was given by Sedgwick adjuster, who never stated we would need out of network approval from Corvel regarding the billing. We were not aware that Corvel would be handling the claims portion of this case."

Amount in Dispute: \$1,100.00

Respondent's Position

"CorVel maintains the Requestor ... is currently not entitled to reimbursement for date of service 02/09/2024 in the amount of \$1100 based on failure to obtain out-of-network approval for the Texas CorCare Network prior to services being rendered in accordance with TIC Sec 1305.103(e).

"... Neither Genesis, nor its individual physicians are participants in the Corvel Texas HCN. To date, CorVel has no record of an out-of-network request from the network Treating Doctor 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. [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 codes:

- 242 – Services not provided by network/primary care prov
- NNP – Non-Network Provider
- L01 – 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
- 18 – Duplicate Claim/Service
- R1 – Duplicate Billing

Issues

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

Findings

1. Charles W. Hebert, D.C. submitted this medical fee dispute for resolution according to 28 TAC §133.307. The dispute concerns an examination to determine maximum medical improvement and impairment rating performed on February 9, 2024. Per the submitted documentation, the injured employee's claim is within the CorVel Texas CorCare healthcare certified network. The requestor is not within the CorVel Texas CorCare network. Therefore, 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 TLC legislation and rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of TIC, Chapter 1305, are applicable to DWC's ability to apply the TLC legislation 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 titled *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 a condition or conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor has submitted insufficient documentation to prove that any of the conditions outlined in TIC §1305.006 applied to the disputed services.

As a result, DWC finds that the insurance carrier is not liable for the out-of-network 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.

DWC finds the requestor has not established that reimbursement is due.

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

September 5, 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. 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 electrónico CompConnection@tdi.texas.gov.