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
4600 TEXAS GROUP

Carrier's Austin Representative
Box Number 11

MFDR Date Received
October 30, 2009

Respondent Name
ARROWOOD INDEMNITY CO

MFDR Tracking Number
M4-10-1595-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Subclaimant, Scott and White Health Plan, has a financial interest in this matter by virtue of payment of compensable medical costs, and is qualified under Sec. 409.009(2) and Sec. 409.0091 because the Carrier has refused reimbursement of the compensable benefits after request. Scott and White Health Plan has complied with the requirements of Tex. Labor Code Section 409.0091."

Amount in Dispute: $270.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 17, 2010. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
Unspecified on the table of disputed services	Unspecified on the table of disputed services	$270.48	$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. The provisions of Texas Labor Code §§409.009, and 409.0091 apply to dispute resolution.
2. Texas Labor Code §409.0091 applies to dates of injury on or after September 1, 2007 **except** as provided by Texas Labor Code §409.0091(s).
3. Texas Labor Code §409.0091(s) applies if information was provided to a health care insurer before January 1, 2007 under Texas Labor Code §402.084(c-3). The health care insurer may file for reimbursement from the workers' compensation carrier not later than March 1, 2008; and may file a subclaim with the Division, if the request for reimbursement has been presented and denied not later than March 1, 2008.
4. Texas Labor Code §409.0091(f) relates to the form and manner in which the health care insurer shall file for reimbursement from the workers' compensation insurance carrier.
5. 28 Texas Administrative Code §§140.6, 140.8 and 28 Texas Administrative Code §133.307 set out the procedures for health insurers to pursue medical fee dispute resolution.

Issues

In reference to the health care insurer /subclaimant's request for medical fee dispute resolution, the Division will address the following:

- Did the requestor file for dispute resolution in accordance with Texas Labor Code §409.009?
- Did the requestor file for dispute resolution in accordance with Texas Labor Code §409.0091?
- Did the requestor file for dispute resolution in accordance with 28 Texas Administrative Code §133.307?

In reference to the health care insurer's / subclaimant's request for reimbursement from the workers' compensation insurance carrier, the Division will address the following:

- Was the requestor eligible to file for reimbursement from the workers' compensation insurance carrier under Texas Labor Code §409.0091?
- Did the requestor file for reimbursement from the workers' compensation insurance carrier in a timely manner as defined by Texas Labor Code §409.0091(s)?
- Did the requestor file for reimbursement from the workers' compensation insurance carrier in the form and manner prescribed by Texas Labor Code §409.0091(f)?

Findings

A document titled "Affidavit of Caldwell Fletcher" along with other documentation found in the dispute point to the requestor's wish to be considered a sub-claimant under Texas Labor Code §409.009.

1. **Subclaimant under Texas Labor Code §409.009**

   Texas Labor Code §409.009 allows for any person who has provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee and has sought and been refused reimbursement by the insurance carrier may pursue dispute resolution. 28 Texas Administrative Code §140.6 sets out the procedures for a subclaimant under §409.009 to file for medical dispute resolution.

   28 Texas Administrative Code §140.6 states, in pertinent part, that subclaimants must pursue a claim for reimbursement of medical benefits and participate in medical dispute resolution in the same manner as an injured employee or in the same manner as a health care provider, as appropriate, under Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments).

   Improper Billing. The Requestor has provided no information that: (a) the Respondent billed the insurance carrier utilizing the required standard forms used by the Center for Medicare and Medicaid Services in accordance with 28 Texas Administrative Code §133.10(a)(1); (b) the Respondent billed the carrier no later than the 95th day after the date the services are provided in accordance with 28 Texas Administrative Code §133.20(b); (c) the requestor included correct billing codes from the applicable Division fee guidelines in accordance with 28 Texas Administrative Code §133.20 (c) and §134.203 (b)(1) that requires use of Medicare payment policies including its coding and billing; and/or (e) that the services were directly supervised by a licensed health care provider as required by 28 Texas Administrative Code §134.203(e)(2). Therefore, because the Requestor has not met any or the entire rule requirements specified, consideration has not been given to the merits of the request for reimbursement.

   Improper Medical Fee Dispute Resolution Request. The Requestor was required to complete its request for medical fee dispute resolution on Division Form DWC060 and attach the "Table of Disputed Services" in accordance with 28 Texas Administrative Code §133.307(c). Rather than completing that Table and for each date of service, listing the applicable CPT Code(s), Medical Fee Guideline MAR amount, and County Where Services were Rendered, the Requestor simply referred to a total amount in dispute as $270.48. The attachment to that Table consisted of claim summaries and a "Workers Compensation Itemization" prepared by The 4600 Group that contained summary of services that were provided. This information does not comply with the requirements of a request for medical fee dispute resolution that include providing "…the form DWC060 table listing the specific disputed health care and charges in the form and manner prescribed by the Division and a position statement of how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues and how the submitted documentation supports the requestor's position for each disputed fee issue in accordance with 28 Texas Administrative Code §133.307(2) and (2)(C), and (F)(iii) and (iv). The Division's medical fee dispute resolution rule authorizes no consideration of requested reimbursement amounts if the requestor has not complied with these specified rules. Therefore, consideration has not been given to the merits of the requested reimbursement amounts. Furthermore, notwithstanding the above-specified deficiencies, no computation of any reimbursement amounts is possible without the applicable bills, which would help identify in which locality the services were rendered in order to determine the MAR amount.

2. **Subclaimant under Texas Labor Code §409.0091**

Texas Labor Code §409.0091 outlines the process by which a health care insurer as defined by Texas Labor Code §402.084(c-1) may be reimbursed by a workers' compensation insurance carrier. A data match under Texas Labor Code §402.084(c-3) is therefore required by Texas Labor Code §409.0091(s).

Data Match Requirement Not Met. The requestor provided a document titled "Affidavit of Caldwell Fletcher" which indicates that a data match occurred on July 9, 2007. On April 28, 2009, MFDR requested the original data file sent from the Division with the data matches so that we [MFDR] may verify the information. As stated in the affidavit, documentation to sufficiently support that a data match occurred on July 9, 2007 was not provided. Therefore, the requestor is not eligible to file for reimbursement under Texas Labor Code §409.0091. Additionally, a data match had to have occurred before January 1, 2007 in order for the health care insurer (the requestor in this dispute) to file for reimbursement from the workers' compensation insurance carrier. The requestors alleged data match date of on July 9, 2007 does not meet the requirements of Texas Labor Code §409.0091(s). No documentation was found to support that a data match occurred on July 9, 2007; therefore, the requestor was not eligible to file for reimbursement from the workers' compensation insurance carrier.

Untimely Submission for Reimbursement. The requestor provided insufficient documentation to support that a request for reimbursement was filed before March 1, 2008. Additionally, the requestor was not eligible to file for reimbursement from the workers' compensation carrier because the data match requirements in Texas Labor Code §409.0091 (s) were not met as discussed above.

Improper Submission for Reimbursement. Texas Labor Code §409.0091(f) states in pertinent part "…the health care insurer shall provide, with any reimbursement request, the tax identification number of the health care insurer and the following to the workers' compensation insurance carrier, in a form prescribed by the Division: (1) information identifying the workers' compensation case, including: … and (2) information describing the health care paid by the health care insurer, including..." The Division prescribed DWC Form-026 to meet the requirements under Texas Labor Code §409.0091(f). No documentation was found to sufficiently support that the requestor included DWC Form-026 with the request for reimbursement. The dates of service and the pertinent description of the services (e.g. ICD-9, CPT, HCPCS, NDC or revenue code), among other information required by that form, were not provided moreover, the Requester simply referred to "see attached" and a total amount. Therefore, the requestor was not eligible for reimbursement because the request was not filed in the form and manner prescribed by the Division.

Conclusion

For each of the reasons stated, the Division finds that the requestor has failed to establish that reimbursement for $270.48 is due. As a result, the amount ordered is $0.00.

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

		January 21, 2015
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.