



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

UNITED HEALTHCARE

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-10-3238-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

March 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "United Healthcare Services asserts that it paid medical service claims totaling \$388.00 which clearly should have been billed to, and paid in good faith by the workers' compensation carrier in this case. The carrier has never disputed the compensability of the injury. The carrier has never offered a substantive objection to the compensability of the services."

Amount in Dispute: \$388.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to Texas Labor Code 409.010 self-insured has 120 days to respond after receipt of the additional information. 120 days form 01/27/10 is 05/13/10, and therefore if this dispute is processed self-insured will be denied the 120 days allowed by statute. This is especially true in a case such as this where the requestor asserts that the limitations of its administrative system precludes it from properly proving-up its claim."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 5, 2008, A0429 x 2, A0382, \$388.00, \$388.00

FINDINGS AND DECISION

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

Background

- 1. Texas Labor Code §409.0091 sets out the requirements for health care insurers to bill for and receive reimbursement from workers' compensation carriers for services provided to covered Texas injured employees.
2. 28 Texas Administrative Code §102.3 applies to the computation of time.
3. 28 Texas Administrative Code §140.7 applies to Health Care Insurer Reimbursement.
4. 28 Texas Administrative Code §140.8 applies to Reimbursement of Medical Benefits.
5. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Did the health care insurer timely file a request for reimbursement from the workers' compensation insurance carrier?
2. Were the workers' compensation insurance carrier denial reasons supported?
3. Is reimbursement due to the health care insurer?

Findings

Texas Labor Code §409.0091 was added by Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 8, and is effective for dates of injury on or after September 1, 2007, with few exceptions. The requestor of this medical fee dispute is Medrecovery management. Medrecovery management is an authorized representative of United Healthcare - a health care insurer as defined by Texas Labor Code §409.0091(a). Medrecovery management and United Healthcare are collectively referred to as the subclaimant for the purposes of this medical fee dispute. Texas Labor Code §409.0091(c) states that health care paid by a health care insurer may be reimbursable as a medical benefit. The subclaimant alleges it paid for services provided to an injured employee with a compensable Texas workers' compensation claim and is seeking to recover \$388.00 from Metropolitan Transit Authority - a Texas workers' compensation insurance carrier – hereto after referred to as the carrier. The provisions of Texas Labor Code §409.0091, and 28 Texas Administrative Code Rules §§140.7 and 140.8 apply to this request for reimbursement and are hereby considered.

1. In order for the subclaimant to recover amounts it paid on behalf of the injured employee that received the services in dispute, the subclaimant must request reimbursement from the carrier in the form, manner and timeframes prescribed by Texas Labor Code §409.0091. Two concurrently running deadlines limit the subclaimant's timeframe for a request for reimbursement from the carrier. These are found at Texas Labor Code §409.0091(n). The subclaimant's submission for reimbursement must be sent not later than six months from the date of a data match, and not later than 18 months from the date that the subclaimant originally paid health care providers for the services in dispute. The division now considers the available documentation in order to establish the date of a request for reimbursement, the data match date, and the date that the subclaimant originally paid for the services in dispute.

Date of Request for Reimbursement

The subclaimant is required to provide the information denoted in Texas Labor Code §409.0091(f) with any request for reimbursement it makes to the carrier. Division rule at Title 28 Texas Administrative Code §140.8(c) (1) requires that the request for reimbursement "be in the form and manner prescribed by the Division of Workers' Compensation (Division) and must contain all the required elements on the form." The division prescribed DWC Form-026 titled *REQUEST FOR REIMBURSEMENT OF PAYMENT MADE BY THE HEALTH CARE INSURER* for use by subclaimants when making a request for reimbursement pursuant to §409.0091.

The subclaimant alleges that it first billed the carrier using DWC Form-026 on December 9, 2009. Review of the documentation available finds correspondence dated February 5, 2010 from Metropolitan Transit Authority. The letter is addressed to United Healthcare Services to the attention of Rachel Bennett and states that "On January 5, 2010, we received your DWC-26 form requesting reimbursement for the above named patient, date of service, and billed amount." This correspondence referred to the same injured employee, and date of service involved in this medical fee dispute.

The division therefore concludes that the subclaimant billed the carrier on or about December 9, 2009 and the carrier acknowledged that it received the DWC Form 26 on January 5, 2010.

Data Match Date

The requestor alleges that it received a data match pursuant to Texas Labor Code §402.084(c-3) from the division on November 19, 2009. A sworn affidavit dated February 1, 2010 and signed by Susan Esford, a representative of the subclaimant, affirms that a response file named tx161510689142073027411289245251p20091026091015.zip was sent by the division and received by the subclaimant. The subclaimant further affirms that the file contained 11,400 separate matches including one match to the name, and division-assigned claim number consistent with the injured employee identified as the recipient of the services in dispute. Comparison to the division's records supports the assertions made by the requestor in the sworn affidavit.

The division finds that the subclaimant reasonably supported that it received a data match on November 19, 2009 identifying the injured employee that received the service in dispute.

Payment Dates

A document titled "United Healthcare– TX Billing Transmittal" which identified the injured employee that received the services in dispute, and supports that the health care insurer or subclaimant:

- paid \$332.00 to Houston EMS – City of Houston, tax id 746001164 on November 21, 2008, for ambulance services totaling \$415.00, provided on November 5, 2008.
- paid \$36.00 to Houston EMS – City of Houston, tax ID 746001164 on November 21, 2008, for ambulance services totaling \$45.00, provided on November 5, 2008.
- paid \$20.00 to Houston EMS – City of Houston, tax id 746001164 on, November 21, 2008, for ambulance services totaling \$25.00, provided on November 5, 2008.

The division finds that the subclaimant supported that it paid for the services in dispute.

Comparison of the data match date to the date that the carrier acknowledged receipt of a request for reimbursement from the subclaimant finds that the subclaimant billed the carrier within the required 6 month deadline. Furthermore, comparison of the dates that the subclaimant paid for the services in dispute to the billing date finds that the subclaimant sent a request for reimbursement from the carrier within the required eighteen month deadline. The division concludes that the subclaimant met both timeliness requirements of Texas Labor Code §409.0091(n).

2. On February 5, 2010, the carrier sent a letter to the subclaimant explaining why the subclaimant's request for reimbursement was not processed. This letter reads, in pertinent part:

On January 9, 2010, we received your DWC-26 form requesting reimbursement for the above named patient, date of service, and billed amount. In order to assist us with your request, please provide the following information:

- Electronic Claims Data Match Report provided by the DWC under Section 402.084 c-3.

In regards to the data match date, Texas Labor Code §409.0091 does not specifically require a data match date, nor does it require the subclaimant to provide the "data match report" with the initial request for reimbursement. In its response to the request for a "data match report" the subclaimant responded by stating that:

We cannot submit documentary evidence to that effect...Neither are we able to share a copy of the matching file since these files are very large and contain confidential information on a large number of individuals and workers' compensation cases...To address your concerns with how and when this case was identified by United Healthcare, we offer the enclosed sworn affidavit.

The subclaimant raises legitimate concerns over the request for the data match report by the respondent. In lieu of the entire data match report, the subclaimant offered a sworn affidavit attesting to the data match file named tx161510689142073027411289245251p20091026091015.zip dated February 1, 2010. The affidavit contained very detailed information about the data match request file to the division, and response file from the division. The division compared the data match information on the sworn affidavit to its records and was able to verify the existence of a data match containing information related to the specific injured employee involved in this medical fee dispute. The division finds that the information provided is reasonable and sufficient to support both that a data match occurred, and that the data match included the injured employee that received the services in dispute.

Review of the information and documentation provided including the initial DWC Form-026 and the subsequent information provided by the subclaimant finds that the workers' compensation insurance carrier possessed the information necessary to resolve a reimbursement request for the services in dispute.

The division's medical fee dispute resolution program concludes that the information and documentation provided by the subclaimant is sufficient to substantiate that a complete and timely request for reimbursement was made. For that reason, the division finds that the services in dispute are eligible for payment pursuant to Texas Labor Code §409.0091(h).

3. For the disputed ambulance service codes, no division fee guideline exists therefore reimbursement must be a fair and reasonable amount as specified in §134.1(f).

(f) Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The amounts the subclaimant paid for ambulance are also the amounts the subclaimant is seeking to recover in this medical fee dispute. Texas Labor Code §409.0091(h) states, in pertinent part that:

In the absence of a fee guideline for a specific service paid, the amount per service paid by the health care insurer **shall** be considered in determining a fair and reasonable payment under rules under this subtitle defining fair and reasonable medical reimbursement.

In this case, the amount that the subclaimant is seeking is the same amount it paid for services provided to the injured employee covered by the workers' compensation carrier. This fact, in and of itself, meets the criteria for a fair and reasonable amount of reimbursement because the requested reimbursement is for the same procedures provided in the same circumstance to the same individual injured employee. No comparison is therefore needed to establish whether the amounts paid by the subclaimant meet the criteria that "values assigned for services involving similar work and resource commitments." The division concludes that the amount paid by the health care insurer is fair and reasonable. The remaining services are therefore allowed for reimbursement as follows:

Date	Service Code	Fee Rule 28 TAC	Bill Amount	Amount Paid by HCI	\$409.0091(h) No Fee Guideline
11/5/2008	A0429	None	\$415.00	\$332.00	\$332.00
11/5/2008	A0429	None	\$45.00	\$36.00	\$36.00
11/5/2008	A0382	None	\$25.00	\$20.00	\$20.00
					\$388.00

The Division finds that the total recommended allowable for the services in dispute is \$388.00.

Conclusion

The division concludes that the subclaimant’s request for reimbursement is sufficiently supported. Reimbursement in the amount of \$388.00 is recommended. Pursuant to Texas Labor Code §409.0091(h), the subclaimant may not recover interest as part of this subclaim.

The division emphasizes that medical fee dispute outcomes rely upon the assertions presented by the requestor and respondent during dispute resolution and during the medical billing process. Although all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The division hereby ORDERS the respondent to remit to the requestor the amount of \$388.00, without interest, due within 30 days of receipt of this Order.

Authorized Signature

		March 31, 2016
Signature	Medical Fee Dispute Resolution Manager	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 MFDR 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 this *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.