



# 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**

HEALTHCARE SUBROGATION GROUP

**Respondent Name**

MERIDIAN SECURITY INSURANCE COMPANY

**MFDR Tracking Number**

M4-20-2727-01

**Carrier's Austin Representative**

Box Number 1

**MFDR Date Received**

July 17, 2020

**Response Submitted By:**

Aetna/Coventry

#### REQUESTOR'S POSITION SUMMARY

The subclaimant/requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

#### RESPONDENT'S POSITION SUMMARY

"I have contacted both filing party Healthcare Subrogation Group and the Decatur Hospital Authority on multiple occasions and faxed a request to the facility in an attempt to receive a copy for the UB92 billing with no response . At this time, we kindly request this MFDR be dismissed, as noted above this is not the correct venue for subrogation, and the rules of MFDR filing have not been met."

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 16, 2018	Facility and Professional Services	\$7,404.26	\$0.00

#### FINDINGS AND DECISION

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

#### Background

1. TLC §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 (TAC) §102.3 applies to the computation of time.
3. 28 TAC §140.7 applies to Health Care Insurer Reimbursement.
4. 28 TAC §140.8 applies to Reimbursement of Medical Benefits.
5. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

## Issues

Did the subclaimant meet the requirements outlined in TLC §409.0091?

## Findings

TLC §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 Healthcare Subrogation Group. Healthcare Subrogation Group is an authorized representative of Anthem - a health care insurer as defined by TLC §409.0091(a). Healthcare Subrogation Group and Anthem are collectively referred to as the subclaimant for the purposes of this medical fee dispute.

TLC §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 \$7,404.26 from Meridian Security Insurance Company - a Texas workers' compensation insurance carrier – hereto after referred to as the carrier. The provisions of TLC §409.0091, and 28 TAC Rules §§140.7 and 140.8 apply to this request for reimbursement and are hereby considered.

1. TLC §409.0091(n) states, “(n) Except as provided by Subsection (s), a health care insurer must file a request for reimbursement with the workers' compensation insurance carrier not later than six months after the date on which the health care insurer received information under Section [402.084](#)(c-3) and not later than 18 months after the health care insurer paid for the health care service.”

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 TLC §409.0091. Two concurrently running deadlines limit the subclaimants timeframe for a request for reimbursement from the carrier. These are found at TLC §409.0091(n).

The subclaimants 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 DWC now considers the available documentation to establish the date of the data match, the date of the request for reimbursement, and the date that the subclaimant originally paid for the services in dispute.

### DATE OF THE DATA MATCH

The subclaimant alleges that the date of the data match is January 29, 2020. The DWC confirmed that the subclaimant received a data match pursuant to Section [402.084](#)(c-3) on January 29, 2020. As a result, the DWC finds that the subclaimant received a data match for to an injured employee with a compensable Texas workers' compensation claim.

### REQUEST FOR REIMBURSEMENT – 6 MONTH TIMEFRAME

The subclaimant alleges that it first billed the carrier using DWC Form-026 on April 14, 2020 and included a reimbursement request letter dated April 14, 2020 along with a fax confirmation dated April 14, 2020.

Review of the documentation available finds correspondence referred to the same injured employee claim, and dates of service involved in this medical fee dispute. The DWC finds that the date of the data match is January 29, 2020 and the date the DWC-26 was submitted for review is April 14, 2020. As a result, the 6-month timeframe was met.

### DATE THE SUBCLAIMANT ORIGINALLY PAID FOR THE SERVICES – 18 MONTH TIMEFRAME

The DWC now considers whether the subclaimant met the 18-month timeframe as required by TLC §409.0091(n), which states, “The subclaimants submission for reimbursement must be sent not later ... 18 months from the date that the subclaimant originally paid health care providers for the services in dispute.”

The DWC finds that the subclaimant submitted no documentation to support that the 18-month timeframe was met.

2. The subclaimant is required to provide the information denoted in TLC §409.0091(f) with any request for reimbursement it makes to the carrier. DWC rule at Title 28 TAC §140.8(c) (1) requires that the request for reimbursement “be in the form and manner prescribed by the Division of Workers’ Compensation and must contain all the required elements on the form.”

The DWC 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.

Review of the DWC-26 finds that the subclaimant did not included all the required information, specifically, the “provider’s FEIN” was not identified on the DWC-26 table. As a result, the DWC finds that the subclaimant has not identified minimum information required when submitting the DWC026 request for reimbursement for consideration to the workers compensation insurance carrier.

3. The DWC’s medical fee dispute resolution program concludes that the information and documentation provided by the subclaimant is insufficient to substantiate that a complete and timely request for reimbursement was made. For that reason, the DWC finds that the services in dispute are ineligible for payment pursuant to TLC §409.0091.

### **Conclusion**

For each of the reasons stated, the Division finds that the requestor has failed to establish that reimbursement in the amount of \$7,404.26 is due. As a result, the amount ordered is \$0.00.

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Signature	Medical Fee Dispute Resolution Officer	October 23, 2020 Date
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### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 TAC §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 TAC §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**