DOCKET NO. 454-10-4433.M4

_____,	**§**	**BEFORE THE STATE OFFICE**
Requestor	**§**	
	§	
V.	**§**	**OF**
	§	
LIBERTY MUTUAL INSURANCE	**§**	
COMPANY,	**§**	
Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

_____ (Requestor) requested a hearing to contest the Medical Fee Dispute Resolution decision of the Texas Department of Insurance, Division of Workers' Compensation (Division), denying payment for home health care services she provided to ____. This decision finds that Requestor is not entitled to any reimbursement.

II. JURISDICTION, NOTICE AND PROCEDURAL HISTORY

This proceeding presented no contested issues of notice or jurisdiction. Therefore, those matters are set out in the proposed findings of fact and conclusions of law without further discussion here.

On October 20, 2010, Administrative Law Judge (ALJ) Hunter Burkhalter convened the hearing in this matter at the Austin offices of the State Office of Administrative Hearings (SOAH). Requestor appeared *pro se*. Respondent was represented by attorney Robert F. Josey. The record was held open to allow the parties to submit legal briefing. Requestor filed legal briefing on November 5, 2010. Liberty Mutual Insurance Company (Respondent or Liberty Mutual) filed its legal briefing on November 10, 2010, and the record closed on that date.

III. DISCUSSION

A. Applicable Law

The Texas Workers' Compensation Act (Act) is found at TEX. LAB. CODE § 401.001, *et seq*. Under the Act, workers' compensation insurance covers all medically necessary health care, including all reasonable and necessary medical aid, examinations, treatments, diagnoses, evaluations, and services reasonably required by the nature of a compensable injury and reasonably intended to cure or relieve the effects naturally resulting from the compensable injury.[1] The Act directs the Commissioner of Workers' Compensation (Commissioner) to adopt rules governing the procedures by which reimbursement of covered medical charges is to be obtained.[2] The Commissioner has adopted such rules.[3] The Act also generally mandates that any health care provider seeking compensation for covered expenses must submit his or her claim for payment to the workers' compensation insurer "not later than the 95th day after the date on which the health care services are provided to the injured employee."[4]

In this case, the Respondent contends that Requestor failed to comply with numerous applicable reimbursement procedures set forth in the Act and implementing rules and, therefore, is not entitled to any reimbursement for the medical services she provided to an injured employee.

B. Evidence and Argument

Requestor and ___ are ex-spouses, having divorced in the late 1990's. Around the time of the divorce, Requestor decided to work in ____ as what she calls a "___." Although one may obtain a license to work as a ___, Requestor never attempted to obtain such a license, and a license is not required. She has no formal training as ___, all of her experience having been gained on the job.

[1] TEX. LAB. CODE § 401.011(19) and (31).

[2] TEX. LAB. CODE § 413.011.

[3] *See, e.g.*, 28 TEX. ADMIN. CODE chs. 133 and 134.

[4] TEX. LAB. CODE § 408.027.

Requestor also occasionally works as a __. She generally earns between $12 and $15 per hour as a __ and ___.

Requestor first began working as a ___ in 1997, when she took care of an elderly man and lived in the man's home. In that first job, she earned $650 per week. She never produced any formal bill for her services during that first job, and she has never prepared bills for her services throughout her career. _____ has, at times, worked with an agency called ____. At other times, she has worked on her own. When she does work through the agency, the agency sends out bills on her behalf. Importantly for this case, Requestor admits that none of her services as a ___ has ever been billed under the auspices of a medical doctor.

In ____, Requestor's ex-husband became very ill.[5] At that time, Requestor had just recently returned to Texas after having worked as a ___ in Chicago, and she was unemployed. At the request of their son, she went to see ___ in the hospital. Requestor told __ that she would help him and "we would get his life back in order." She spoke to ___ doctors, who told her that he could not be left alone and needed 24-hour care.

Requestor was told that, when ___ was discharged from the hospital, the doctors expected that he would be receiving 24-hour care. She is "pretty sure" that a physician wrote a prescription for ____ to receive 24-hour care. She also thinks Dr. R wrote a letter in which he stated that ___ needed 24-hour care. Requestor did not, however, produce copies of such a prescription or letter. According to Requestor, she and ____ agreed among themselves that she would be the person to provide the 24-hour care. Requestor claims that ___ told her she would be paid for her work. She denies that she helped ____ as a volunteer.

During the period from early December 2005 to mid-November 2008, Requestor lived at __ home and took care of him. For the first few months, ___ was bedridden and could do very little for

[5] __ suffered a work-related injury in ___ and suffers from lingering problems associated with that injury. Requestor contends that the health problems ___ began experiencing in ___ stemmed from the ___ injury and, as such, are covered by his workers' compensation insurance. There is evidence to suggest that Respondent disagrees. However, the coverage question need not be resolved in this case. The ALJ will simply assume, without deciding, that ___ ailments are work-related.

himself. Requestor bathed and fed him, maintained his house and yard, assisted him in the bathroom, and so on. According to Requestor, if not for her care, ___ would have to have been put in a nursing home.

Requestor claims that, during the period when she cared for ___, she interacted with his doctors "all the time." She accompanied him on doctor visits. His doctors provided her with training on how to deal with his catheter. On many occasions, Requestor would call ___ doctor with questions, such as if he had an infection. She would then follow the doctor's recommendations.

On September 2, 2009, roughly 10 months after she stopped assisting ___, Requestor wrote a letter to Liberty Mutual demanding payment for her services (Requestor's demand letter). A copy of Requestor's demand letter is included in the record.[6] In her testimony, she described the letter as the bill for her services. In the letter, Requestor explains that, from ____ to ____, she took care of ____ "24/7," and that her round-the-clock duties included "bathing, dressing, cooking, cleaning, distributing his medications, shopping, laundry, helping him with his transfers, taking him to doctors visits, and many other daily and nightly duties." In Requestor's demand letter, she requests reimbursement from Liberty Mutual as follows:

> The following is an itemized list of wages per my normal fees:
>
> | | | |
> |---|---|---|
> | Hourly rate | $14.00 x 24 hrs a day | = $336.00 |
> | Weakly [sic] rate | $336.00 x 52 weeks | = $112,896.00 |
> | Yearly rate | $112,896.00 x 3 years | = $338,688.00 |
>
> **Total Due: $338,688.00** (Three hundred thirty-eight thousand, six hundred eighty-eight and 00/100 dollars)
> Due from dates: __ to _____[7]

Requestor admitted that her demand letter was the only written document she has ever sent to Liberty Mutual. Indeed, it is the only document approximating a bill that Requestor has ever sent

[6] Ex. P-3, pp. 5-6.

[7] Ex. P-3, p. 6 (emphasis in original). There appear to be mathematical errors in Requestor's calculations. For example, if we accept her premise that she worked 24 hours per day, 365 days per year, then the yearly rate would be $122,640, not $112,896.

anyone in her career. Requestor offered the opinion that $14/hour is a reasonable hourly rate. Requestor explained that she never sent a bill for her services every 95 days because "nobody told me I was supposed to." She claimed, however, that prior to sending her demand letter, she had spoken with Liberty Mutual representatives over the phone about her services. "I had been on the phone with Liberty Mutual myself, asking them to pay me, and so has my ex-husband, and I do believe even his doctor requested it." In those conversations, Requestor claims that Liberty Mutual told her they would not pay her because ___ physical maladies were caused not by work-related injuries, but by multiple sclerosis.

On September 21, 2009, 19 days after sending her demand letter to Respondent, Requestor filed a "Medical Fee Dispute Resolution" request (MDR) with the Division.[8] By filing the form, Requestor initiated this proceeding.

___ testified and explained that the physical ailments he suffers from originated from his ____ on-the-job injury. Over the years, his injuries have been treated in part with steroid injections, which have caused unintended further injury to him. In ____, he became paralyzed and was close to death. He spent some time in the hospital and then at the Texas Institute for Rehabilitation and Restoration (TIRR). When he was ready to be discharged from TIRR, a "discharge meeting" was held. ___ was in attendance, along with the various therapists and doctors who had treated him. A Liberty Mutual representative was in attendance too. According to ___, the consensus at the discharge meeting was that he needed someone to care for him. He testified that, "to my feelings," the consensus at the meeting was that Requestor would be the person to care for him. "I was under the understanding that they [Liberty Mutual] would take care of everything."

Not long thereafter, Liberty Mutual apparently began to refuse to pay for 24-hour care for ____, on the grounds that his symptoms were caused by multiple sclerosis, rather than being work-related. ___ called Liberty Mutual frequently, perhaps weekly, in order to get the coverage question resolved. ___ described a long process during which he and his doctor worked to convince Liberty

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[8] Respondent Ex. 3.

Mutual that his ailments arose from his work-related injury rather than from multiple sclerosis. According to ____, the dispute over multiple sclerosis has never been completely resolved. Rather, he contends that Liberty Mutual verbally maintains that he has multiple sclerosis but has never committed that opinion to writing, thereby making it impossible for ___ to legally challenge the position. He believes the multiple sclerosis argument is simply a pretext so that the insurer can avoid paying Requestor.

___ testified that Requestor did a good job in taking care of him and she deserves to be paid. He insists that she was not working as a volunteer. He agrees that Requestor interacted with his doctors frequently, by seeking their advice if he got an infection. ___ believes that Requestor helped his doctors take care of him. ____ and Requestor agreed between themselves that Liberty Mutual would pay her.

Because Liberty Mutual has not paid Requestor, ___ and his company are paying some of Requestor's living expenses, such as food and lodging. They are paying her a small, unspecified amount. He has never sought reimbursement of those expenses from Liberty Mutual.

Liberty Mutual asserts that Requestor failed to comply with a number of requirements of the Act and implementing rules in her effort to seek reimbursement. Specifically, the company makes the following defensive arguments:

Defensive Argument 1: Requestor failed to submit her claim for payment within 95 days after providing the service, in violation of TEX. LAB. CODE § 408.027(a) and 28 TEX. ADMIN. CODE § 133.20(b);

Defensive Argument 2: Requestor's demand letter does not conform to the requirements of a medical bill as set out in 28 TEX. ADMIN. CODE §§ 133.10(a)(1) and 133.20(c);

Defensive Argument 3: Requestor failed to ask Respondent to reconsider its denial of her demand letter within eleven months, as required by 28 TEX. ADMIN. CODE §§ 133.250(a), (h) and 133.307(e)(3)(C);

Defensive Argument 4: With respect to the services she provided from __ through __, Requestor failed to seek Medical Dispute Resolution within one

year of providing the services, in violation of 28 TEX. ADMIN. CODE § 133.307(c)(1)(A);

Defensive Argument 5: Requestor failed to provide proper documentation of services provided, as required by 28 TEX. ADMIN. CODE § 133.210(a), (b);

Defensive Argument 6: Because she lacks a license to practice home health care and does not qualify as a health care practitioner, Requestor was not the proper party to submit a bill, pursuant to 28 TEX. ADMIN. CODE § 133.20(d)(2) and (e)(2);

Defensive Argument 7: Requestor did not provide all the required information when she filed her request for medical dispute resolution with the Division, as required by 28 TEX. ADMIN. CODE § 133.307(c)(2) and (e)(3)(I); and

Defensive Argument 8: Requestor failed to obtain preauthorization for services she provided, as required by 28 TEX. ADMIN. CODE § 134.600(b)(1)(B), (c)(1)(B), (h)(12), (p)(5)(B) and (12).

Liberty Mutual argues that any one of these failures should result in denial of Requestor's claim.

Requestor responds that she provided a valuable and necessary service to ___, and that those services were well within what the legislature intended to be covered when it enacted the Act. Accordingly, Requestor urges the ALJ to avoid "rigid adherence" with the legal requirements and instead, consistent with the "spirit" of the Act, approve payment of Requestor's claim. Additionally, Requestor contends that the real dispute is about whether ___ physical ailments stem from a compensable, work-related injury. According to Requestor, Respondent has failed to commit to writing its conclusion that the ailments are not work-related, thereby stymieing Requestor's efforts to litigate that issue. As such, Requestor essentially contends that Respondent's arguments laid out above are merely a smoke screen for the larger coverage question.

ALJ's Analysis and Decision

Each of Respondent's defensive theories will be discussed in turn.

Defensive Argument 1: Requestor's claim should be denied because she failed to submit her claim within 95 days after providing the service.

The ALJ concludes that Requestor's failure to submit her claim for payment within 95 days after providing the services justifies complete denial of her claim. Pursuant to Section 408.027(a) of the Act, a "health care provider"[9] is obligated to:

> submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. *Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for the claim for payment*.[10]

The Act sets out a limited number of exceptions to this 95-day rule, none of which are applicable in this case.[11] The 95-day rule is reiterated in the Division's rules at 28 TEX. ADMIN. CODE § 133.20(b).

Requestor claims to have provided services to ___ from __ through __. Requestor's "bill," however, was submitted to Respondent on September 2, 2009, roughly 10 months after the last day she provided services to ___. Remarkably, her bill was submitted almost *four years* after the first day of her service. Given these facts, the claim must be denied.

The ALJ rejects Requestor's invitation to avoid rigid adherence to the text of the Act. The statutory language quoted above clearly demonstrates that the legislature intended for the 95-day deadline to have serious consequences. The statute dictates that failure to comply must result in "forfeiture" of the medical provider's right to reimbursement.

Additionally, other provisions in the Division's rules dictate that the 95-day rule must be considered mandatory. For example, as will be discussed in more detail below, if a health care provider is dissatisfied with the insurance carrier's decision on a reimbursement request, then the provider must submit to the carrier a "request for reconsideration no later than eleven months from

[9] As noted above, Respondent contests whether Requestor qualifies as a "health care provider." For purposes of analyzing Argument 1, the ALJ will assume, without deciding, that she does so qualify.

[10] Emphasis added.

[11] TEX. LAB. CODE § 408.272.

the date of service."[12] If a provider were allowed to ignore the 95-day rule and wait years before requesting reimbursement in the first place, then compliance with this 11-month deadline would be impossible.

Finally, the extreme circumstances of this case illustrate the wisdom and necessity of the 95-day rule. If Requestor had submitted a first bill to Respondent by February 2006 (*i.e.*, within 95 days after she began assisting ____) then the question of whether she was entitled to reimbursement could have been resolved much sooner, and at a time when the total costs would have been much more manageable. Instead, she chose to run up a very large tab ($338,688) and seek reimbursement long after the services had concluded. Accordingly, the ALJ concludes that Requestor's entire claim should be denied.

Defensive Argument 2: Requestor's claim should be denied because her demand letter does not conform to the requirements of a medical bill.

Pursuant to 28 TEX. ADMIN. CODE § 133.10(a)(1), a health care provider "shall" submit medical bills for payment "on standard forms used by the Centers for Medicare and Medicaid Services (CMS)." Pursuant to 28 TEX. ADMIN. CODE § 133.20(c), the health care provider "shall" also include "correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service." Respondent contends that because Requestor failed to do so, her claim should be denied.

The ALJ agrees. Requestor's demand letter is clearly not written on a standard form used by CMS, nor does it cite any billing codes. By using the word "shall," the requirements are intended to be mandatory. The rules do not spell out the consequences of a failure to comply. Nevertheless, the Act itself clearly evidences legislative intent to enforce a standardized billing process in the workers' compensation arena. The Act requires the Commissioner to adopt rules setting out reimbursement procedures "that reflect the standardized reimbursement structures found in other health care methodologies" and "adopt the most current reimbursement methodologies . . . used by the federal

[12] 28 TEX. ADMIN. CODE § 133.250(b).

Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting."[13]

The requirements to use a standardized form and billing codes only apply, however, to a portion of the services provided by Requestor. The rules requiring use of a standardized form and inclusion of billing codes are part of chapter 133 of the Division's rules. The rules in that chapter only apply to "all health care provided on or after May 2, 2006."[14] Some of the health care for which Requestor seeks reimbursement was provided prior to May 2, 2006. Thus, the ALJ concludes that, by failing to comply with Sections 133.10(a)(1) and 133.20(c), Requestor is barred from being reimbursed for health care services she provided to ___ on May 2, 2006 and thereafter.

Defensive Argument 3: Requestor's claim should be denied because she failed to ask Requestor to reconsider its denial of her demand letter within eleven months.

Pursuant to 28 TEX. ADMIN. CODE § 133.250(a) and (b), if a health care provider is dissatisfied with the insurance carrier's decision on a reimbursement request, then the provider must submit to the carrier a "request for reconsideration no later than eleven months from the date of service." The submission of a request for reconsideration is a prerequisite to requesting a medical dispute resolution by the Division.[15] If a request for reconsideration is not made, the Division may dismiss the medical dispute resolution request.[16]

The evidence in this case indicates that Requestor submitted her demand letter to Respondent on September 2, 2009. Nineteen days later, she filed a Medical Fee Dispute Resolution request with the Division.[17] She never requested reconsideration from Respondent. Given these circumstances, her claims should be denied.

[13] TEX. LAB. CODE § 413.011(a).

[14] 28 TEX. ADMIN. CODE § 133.1(b).

[15] 28 TEX. ADMIN. CODE § 133.250(h).

[16] 28 TEX. ADMIN. CODE § 133.307(e)(3)(C).

[17] Respondent Ex. 3.

As with Defensive Argument 2, however, the reconsideration requirement only applies to health care services provided ___ on or after ___. Thus, the ALJ concludes that, by failing to comply with Section 133.250(a),(b) and (h), Requestor is barred from being reimbursed for health care services she provided to __ on ___ and thereafter.

Defensive Argument 4: A portion of Requestor's claim should be denied because she failed to seek Medical Dispute Resolution within one year.

Pursuant to 28 TEX. ADMIN. CODE § 133.307(c)(1)(A), if a health care provider wishes to pursue MDR by the Division, then she must file a request for MDR "no later than one year after the date(s) of service in dispute." If a request for MDR is not filed by this deadline, then the provider shall be deemed to have waived the right to MDR.[18]

In this case, Requestor submitted her MDR request to the Division on September 21, 2009.[19] Thus, with respect to all of her services provided to ___ prior to September 21, 2008, her MDR request was untimely. As with Defensive Arguments 2 and 3, the one-year requirement for requesting MDR only applies to health care services provided to __- on or after __. Thus, the ALJ concludes that, by failing to comply with Section 133.307(c)(1)(A), Requestor is barred from being reimbursed for health care services she provided to __ from the dates ____ through ____.

Defensive Argument 5: Requestor's claim should be denied because she failed to provide proper documentation of services provided.

Pursuant to 28 TEX. ADMIN. CODE § 133.210(a) and (b), when seeking reimbursement, a health care provider must provide relevant medical documentation, such as "all medical reports and records, . . . narrative reports, assessment reports, progress reports/notes, clinical notes, hospital records and diagnostic test results."[20] Requestor's demand letter clearly did not include any such documentation. There are no contemporaneous notes or records of the care Requestor provided. Instead, Requestor simply demanded payment for three years of services and claimed to have

[18] 28 TEX. ADMIN. CODE § 133.307(c)(1).

[19] Respondent Ex. 3.

[20] 28 TEX. ADMIN. CODE § 133.210(a) and (b).

provided such services 24 hours per day, seven days per week, and 52 weeks per year. The outlandishness of Requestor's demand letter highlights the wisdom of requiring health care providers to include documentation substantiating the services they claim to have provided. In the absence of such documentation, Requestor should not be entitled to recovery.

Again, 28 TEX. ADMIN. CODE § 133.210(a) and (b) only applies to health care services provided on or after May 2, 2006. Thus, the ALJ concludes that, by failing to comply with Section 133.210(a) and (b), Requestor is barred from being reimbursed for health care services she provided to __ on ___ and thereafter.

Defensive Argument 6: Requestor's claim should be denied because she was not entitled to submit a request for reimbursement in the first place.

Pursuant to 28 TEX. ADMIN. CODE § 133.20(d)(2) and (e)(2) as applied to the circumstances of this case, only a "supervising health care provider" is entitled to seek reimbursement under the Act. A health care provider is defined to include a "health care practitioner."[21] In turn, health care practitioner is defined, in relevant part, as "a nonlicensed individual who provides or renders health care under the direction or supervision of a doctor."[22]

It is undisputed that Requestor is not licensed. At the hearing, Requestor contended that she provided the services to ___ under the direction and supervision of a doctor and, therefore, should be considered a health care provider. Respondent disputed this claim. Substantial evidence and argument was heard on this issue. The ALJ concludes, however, that the question of whether or not she qualifies as a health care provider is, strictly speaking, irrelevant. Under the Division's rules:

> (d) The health care provider that provided the health care shall submit its own bill, unless:
>
> . . .
>
> (2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, *in which case the supervising health care provider shall submit the bill*;
>
> . . .
>
> (e) A medical bill must be submitted:

[21] TEX. LAB. CODE § 401.011(22).

[22] TEX. LAB. CODE § 401.011(21)(B).

. . .

(2) in the name of the licensed health care provider that provided the health care *or that provided direct supervision of an unlicensed individual who provided the health care*.[23]

Thus, even if the ALJ accepts, for the sake of argument, Requestor's premise that she was providing the care under the supervision and direction of a doctor,[24] the rules make it clear that it the bill should have been submitted by, and in the name of, the doctor, not Requestor. As such, Requestor had no right under the applicable laws to submit her "bill" to Respondent in the first place.

Again, this rule only applies to health care services provided on or after ___. Thus, the ALJ concludes that Requestor was not entitled to submit a bill in her name for health care services she provided to __ on ___ and thereafter.

Defensive Argument 7: Requestor's claim should be denied because she failed to obtain preauthorization for home health care and demonstrate that the services she provided were within the Commissioner's treatment guidelines.

Pursuant to the version of 28 TEX. ADMIN. CODE § 133.600 that was in effect during the period from __ through __, an insurer was not liable for the costs of ___ unless the health care provider requested and obtained from the carrier preauthorization prior to providing the care.[25] Under this rule, the health care provider was obligated to submit a detailed, written request for preauthorization, and the carrier was obligated to respond to the request in writing. Because Requestor provided no evidence to establish that such preauthorization was sought or obtained, Respondent contends that the costs must be denied. The ALJ agrees.

[23] 28 TEX. ADMIN. CODE § 133.20(d)(2) and (e)(2)(emphasis added).

[24] In fact, the ALJ is not convinced that Requestor was acting under the supervision and direction of a doctor. She testified that she interacted with __ doctors during his doctor's visits, received instruction from a doctor on how to deal with __ catheter, and occasionally would call a doctor with questions, such as if ___ had an infection. If this were to qualify as "rendering health care under the direction or supervision of a doctor," then essentially every parent who tends to a sick child could be considered a "health care practitioner."

[25] 28 TEX. ADMIN. CODE § 133.600(b) and (h)(12) (2005).

The version of 28 TEX. ADMIN. CODE § 133.600 in effect since May 2, 2006 no longer requires preauthorization for home health care services.[26] However, preauthorization is still required for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols."[27] Respondent contends that, because Requestor's demand letter failed to include vital information such as medical records and properly coded and documented medical bills, it is impossible to ascertain exactly what services were provided and whether or not those services fell within the Commissioner's guidelines. The ALJ agrees. The Requestor bears the burden to prove she is entitled to reimbursement. By failing to provide the information necessary to evaluate her claim, she is barred from recovery.

Thus, by failing to obtain preauthorization for home health care services, Requestor is barred from being reimbursed for health care services she provided to __ from __ through __. By failing to submit documentation sufficient to ascertain whether the services she provided after __ fell within the Commissioner's guidelines, Requestor is barred from being reimbursed for health care services she provided to __ on ____ and thereafter.

IV. FINDINGS OF FACT

1. In __, __ suffered a work-related injury.

2. In __, __ was hospitalized for serious health problems which he contends stemmed from the __ injury.

3. Although the parties dispute whether ___ health problems that started in ___ are work-related, the question of whether those injuries are work-related need not be reached or resolved in this case.

4. ___ (Requestor) is the ex-wife of __.

5. Requestor has worked off and on as a __since 1997.

6. Although a state-issued license is offered for ___, it is not required to work in that field.

7. Requestor has never held a license to work in that field.

[26] 28 TEX. ADMIN. CODE § 133.600.

[27] 28 TEX. ADMIN. CODE § 133.600(c), (f), and (p)(12).

8. When ___ was hospitalized ___, Requestor was asked by the son of Requestor and __ to assist ___ after he was released from the hospital.

9. When he was released from the hospital, ___ was informed by his doctors that he would need 24-hour care.

10. Requestor agreed to live in ___ home and provide him with such care.

11. Requestor did so from early ___ through _____.

12. During the first few months of that time period, ___ was bedridden and could do very little for himself. Requestor bathed and fed him, maintained his house and yard, assisted him in the bathroom, and so on. As time progressed, ____ was able to take care of himself more and more.

13. During the period when she cared for ____, Requestor would occasionally interact with his doctors, such as by accompanying him on doctor visits, and calling a doctor when she had a question, such as if ____ had an infection. His doctor also explained to her how to deal with ____ catheter.

14. On ___, roughly 10 months after she stopped assisting ___, Requestor wrote a letter to Liberty Mutual Insurance Company (Respondent) demanding payment for her services to __ (Requestor's demand letter).

15. In Requestor's demand letter, she asserted that she cared for __ for 24-hours per day, for every day between __ and __. She demanded payment of $338,688, which she asserted represents $14 per hour for every hour between those two dates.

16. Requestor's demand letter is the only written document she ever sent to Respondent.

17. Requestor's demand letter does not constitute an itemized medical bill, was not on a standard form used by the Centers for Medicare and Medicaid Services (CMS), did not cite to correct billing codes from the applicable Division fee guidelines in effect on the dates of service, and did not include relevant and necessary documentation to substantiate the services allegedly provided.

18. Requestor never submitted any claim for payment to Respondent within 95 days after any of the services she provided to _____.

19. Requestor did not submit to Respondent a request for reconsideration within 11 months from the date of her services.

20. As to those services provided by her prior to September 21, 2008, Respondent failed to submit an MDR request to the Division within one year after the date the services were

provided.

21. Respondent failed to request and obtain from the carrier preauthorization prior to providing home health care services to ___ during the period __ through ___.

22. Requestor's demand letter failed to include vital information such as medical records and properly coded and documented medical bills, thereby making it is impossible to ascertain whether or not those services fell within the Commissioner's guidelines.

23. On September 21, 2009, only 19 days after sending her demand letter, Requestor filed a request for medical dispute resolution (MDR) with the Texas Department of Insurance, Division of Workers' Compensation (Division).

24. The Division determined that Requestor was not entitled to reimbursement.

25. Requestor requested a hearing with the State Office of Administrative Hearings, seeking reversal of the Division's decision.

26. The Division mailed notice of the hearing on May 28, 2010. The notice of hearing listed the time, place, and nature of the hearing; included a statement of the legal authority and jurisdiction under which the hearing was to be held; referred to particular sections of the statutes and rules involved, and included a short, plain statement of the matters asserted.

27. The hearing convened on October 20, 2010. Both parties appeared and participated. The record closed on November 10, 2010, to allow the parties to submit post-hearing briefing.

28. Requestor is not entitled to reimbursement for her services.

V. CONCLUSIONS OF LAW

1. The Division has jurisdiction over this matter pursuant to TEX. LABOR CODE §413.031.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding pursuant to TEX. GOV'T CODE ch. 2003.

3. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§ 2001.051 and 2001.052 and 1 TEX. ADMIN. CODE ch. 155.

4. Requestor had the burden of proof under 28 TEX. ADMIN. CODE § 148.14.

5. Because Requestor did not submit her claim for payment to Respondent within 95 days after providing her services, her entire claim was forfeited and should be denied, pursuant to TEX. LAB. CODE § 408.027(a).

6. Because Requestor did not submit her claim for payment on a standard form used by CMS

7. Because Requestor did not submit a request for reconsideration to Respondent within 11 months from the date of her services, she is barred from being reimbursed for services she provided to ___ on ___ and thereafter, pursuant to 28 TEX. ADMIN. CODE § 133.250(a) and (b).

8. Because Requestor did not file an MDR request with the Division within one year after the dates of much of her services, she is barred from being reimbursed for services she provided to ___ from the dates __ through __, pursuant to 28 TEX. ADMIN. CODE § 133.307(c)(1)(A).

9. Because Requestor failed to include required documentation with her demand letter, she is barred from being reimbursed for services she provided to __ on ___ and thereafter, pursuant to 28 TEX. ADMIN. CODE § 133.210(a) and (b).

10. Because Requestor is unlicensed, she was not entitled to submit a medical bill in her name, pursuant to 28 TEX. ADMIN. CODE § 133.20(d)(2) and (e)(2). Accordingly, she is barred from being reimbursed for services she provided to ___ on ____ and thereafter.

11. Because Requestor did not request or receive preauthorization for home health care services, a service that required preauthorization pursuant to 28 TEX. ADMIN. CODE § 134.600(b) and (h)(12)(2005), she is barred from being reimbursed for services she provided to ___ from ___ through ___.

12. Because Requestor did not submit documentation sufficient to ascertain whether the services she provided after __ fell outside the Commissioner's guidelines, and therefore would have required preauthorization pursuant to 28 TEX. ADMIN. CODE § 134.600(c), (f), and (p)(12), she is barred from being reimbursed for services she provided to ___from __ and thereafter.

ORDER

THEREFORE IT IS ORDERED that ___ is not entitled to any reimbursement from Liberty Mutual Insurance Company, and her reimbursement request is **DENIED**.

SIGNED November 29, 2010.

HON. TIM SULTER
ADMINISTRATIVE LAW JUDGE/MEDIATOR
STATE OFFICE OF ADMINISTRATIVE HEARINGS