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
United Healthcare

Respondent Name
ST PAUL FIRE & MARINE INSURANCE

MFDR Tracking Number
M4-09-7233-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
March 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "United Healthcare asserts that it paid medical service claims totaling $7,823.31 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: $7,823.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As documented by the EOBs attached hereto, the Carrier in this instance has reimbursed the medical providers directly for the services the dates of service submitted by the Subclaimant as identified above…The carrier contends the Provider is not entitled to reimbursement."

Response Submitted by: Travelers, 1501 S Mopac Expressway, Suite A320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2003 – June 10, 2003	Medical Treatment	$7,823.31	$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. Texas Labor Code §409.0091 sets out the reimbursement procedures for health care insurers.
2. Texas Labor Code §409.0091(s) sets out an exception for reimbursement for services provided to injured employees with dates of injury prior to September 1, 2007.
3. 28 Texas Administrative Code §102.3 applies to the computation of time.
4. 28 Texas Administrative Code §140.7 applies to Health Care Insurer Reimbursement under Labor Code §409.0091.
5. 28 Texas Administrative Code §140.8 applies to Reimbursement of Medical Benefits under Labor Code §409.0091.
6. 28 Texas Administrative Code §140.8(h) sets out the conditions for requests by the health care insurer for dispute resolution.
7. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Did the health care insurer meet the applicable requirements of Texas Labor Code §409.0091?
2. Did the workers' compensation insurance carrier fulfill its duties to timely pay, reduce or deny payment?
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 was effective September 1, 2007. The requestor of this medical fee dispute represents a health care insurer as defined by Texas Labor Code §409.0091(a). Texas Labor Code §409.0091(c) states that health care paid by a health care insurer may be reimbursable as a medical benefit. The requestor is seeking $7,823.31. The respondent is a Texas workers' compensation insurance carrier. The health care insurer alleges it paid to health care providers on behalf of an injured employee with a compensable workers' compensation claim. 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 by a health care insurer as asserted.

The services in dispute relate to an injury that occurred on [redacted]. For this reason, the exception under Texas Labor Code §409.0091(s) applies. Pursuant to §409.0091(s), for data matches provided to the health care insurer before January 1, 2007, the health care insurer may not file a request for reimbursement later than March 1, 2008. Review of the documentation provided by the requestor finds the following.

- The requestor alleges that a data match was received from the Division on June 21, 2006 which included and identified the injured employee that received the services in dispute. The date of this data match precedes the required January 1, 2007 date. The Division notes that the carrier did not subsequently raise any defenses related to this data match or the data match date.
- The requestor provided a copy of a DWC Form-026 filed on November 13, 2007 via certified mail 7007 0710 0000 9612 1896. The request included all information and documentation required by §409.0091(f) for the services in dispute.

The Division concludes that the requestor sufficiently supported that it met the conditions of §409.0091(s).

Texas Labor Code §409.0091(i) states "On receipt of a request for reimbursement under this section, the workers' compensation insurance carrier shall respond to the request in writing not later than the 90th day after the date on which the request is received." Review of the documentation finds the following.

- The health care insurer's request for reimbursement sent via certified mail numbered 7007 0710 0000 9612 1896 was received and signed for by the workers' compensation insurance carrier on November 19, 2007.
- 28 Texas Administrative Code §102.3(a)(1) computing a period of days. In counting a period of time measured by days, the first day is excluded and the last day is included. Additionally, 28 Texas Administrative Code §102.3(a)(3) states that, unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day. The respondent was therefore required to respond to the reimbursement request not later than February 19th, 2008. No documentation was found to support that the workers compensation insurance carrier responded by that date.

The Division concludes that the workers' compensation insurance carrier failed to timely respond to the health care insurer's request for reimbursement.

Texas Labor Code §409.0091(l) states that "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Applicable Texas Labor Code §409.0091(k)(1), and corresponding 28 Texas Administrative Code §140.8 (h)(3)(A)(i), in pertinent part, state that a health care insurer must file a request for medical dispute resolution with the Division not later than the 120th day after a workers' compensation insurance fails to respond to the request for reimbursement. 28 Texas Administrative Code §140.8 (h)(3)(B) furthermore states that a dispute based on the workers' compensation insurance carrier's failure to respond to a health care insurer's reimbursement request is subject to dispute resolution under 28 Texas Administrative Code §133.307. The requestor was therefore required to file its request to medical fee dispute resolution not later than 120 days from February 19th, 2008 for the services in this dispute. Review of the documentation finds that the requestor filed for medical fee dispute resolution on March 23, 2009. This date is well past the 120 day filing deadline required by §140.8 (h)(3)(A)(i).

The Division finds that the requestor failed to meet the timeliness condition for filing a medical fee dispute set out by Texas Labor Code §409.0091(k)(1), and corresponding 28 Texas Administrative Code §140.8 (h)(3)(A)(i). For this reason, the medical fee dispute is not eligible for review.

Conclusion

The outcome of this medical fee dispute relied upon the available evidence presented by the requestor and the respondent. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor failed to establish that additional reimbursement is due. As a result, the amount ordered is zero.

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

	Martha P. Luevano	March 30, 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.