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 INC

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 27, 2009

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-09-7857-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Affidavit: "Due to the date of injury above captioned, and the date of match in Exhibit A, it is our position and that of our client that reimbursement is sought under law applicable to this subclaim, Tex. Lab. Code 409.009. Please note that new law in this regard applies only to subclaims identified prior to Jan. 1, 2007 and/or with dates of injury after Sept. 1, 2007."

Amount in Dispute: $1,093.44

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 September 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
Not identified on the Table of Disputed Services	Not identified on the Table of Disputed Services	$1,093.44	$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 applies only to dates of injury on or after September 1, 2007 **except** as provided by Texas Labor Code 409.0091(s).
2. The services in dispute relate to an injury that occurred on [redacted].
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. The requestor may then 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. The provisions of Texas Labor Code §§409.009, and 409.0091 apply to dispute resolution.
6. 28 Texas Administrative Code §§140.6, 140.8 and 28 Texas Administrative Code §133.307 set out the procedures for health care insurers to pursue medical fee dispute resolution.

Issues

In reference to the health care insurer's subclaimant 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, 409.0091, and 28 Texas Administrative Code §§140.6, 140.8?

In reference to the health care insurer's subclaimant 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 (f) or (s)?

Findings

On August 4, 2010, MFDR requested additional information under 28 Texas Administrative Code §133.307(e) (1) from the requestor in this dispute. MFDR requested a position statement to establish whether the request for dispute resolution was made under the authority of Tex. Lab Code §409.009 or §409.0091. The attorney for 4600 Texas Group, Caldwell Fletcher provided an affidavit establishing that the request for resolution is sought under the authority of Tex. Lab Code §409.009. The division will address the request for dispute resolution under both Tex. Lab Code §409.009 and §409.0091.

1. Texas Labor Code §409.009 states, "A person may file a written claim with the division as a subclaimant if the person has: 1) provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and 2) sought and been refused reimbursement from the insurance carrier." Because the requestor alleges to have been denied reimbursement, a dispute may be filed under the appropriate dispute resolution process. Similarly, Texas Labor Code §409.0091 (l) requires 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."

   28 Texas Administrative Code §133.305(4) defines a medical fee disputes as "A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes)." The requestor is therefore required to file pursuant to 28 Texas Administrative Code §133.307.

2. Review of the documentation provided by the requestor finds that the request for dispute resolution was not filed in the manner required by 28 Texas Administrative Code §133.307.

   28 Texas Administrative Code §133.307 (c)(2)(C) states "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division... The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division; requires the DWC060 table be completed in the manner prescribed by the division. Review of the table of disputed services finds that the disputed dates of service, the pertinent description of services and other information required was not included.

   28 Texas Administrative Code §133.307 (c)(2)(F)(i-iv) states "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division... Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: a position statement of the disputed issue(s) that shall include: (i) a description of the health care for which payment is in dispute, (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, (iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the DWC request did not contain a position statement and no subsequent position statement was provided after the request for additional information was made on August 4, 2010. The division finds that the information minimally required to file for dispute resolution was not provided.

   28 Texas Administrative Code §133.307 states "(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The dates of the service in dispute are August 23, 2004 through November 20, 2004. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on April 27, 2009. This date is later than one year after the date(s) of service in dispute. The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

The services in dispute relate to an injury that occurred on [redacted]. A data match under Texas Labor Code §402.084(c-3) is required by Texas Labor Code §409.0091(s) if a subclaim was identified prior to January 1, 2007 and/or with dates of injury after September 1, 2007. The requestor provided a document titled "Affidavit of Caldwell Fletcher" to support that a data match occurred on July 9, 2007.

1. Pursuant to Texas Labor Code §409.0091(s), 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 July 9, 2007 does not meet the requirements of Texas Labor Code §409.0091(s). The requestor submitted no documentation to support that a data match occurred before January 1, 2007; therefore, the requestor was not eligible to file for reimbursement from the workers' compensation insurance carrier.

2. The request for reimbursement by 4600 Texas Group from the workers' compensation insurance carrier was not filed in the form and manner prescribed by Texas Labor Code §409.0091(f). DWC Form-026 was established to meet the requirements under Texas Labor Code §409.0091(f). The requestor submitted insufficient documentation to support that the requestor included a complete DWC Form-026 with the request for reimbursement to the workers' compensation insurance carrier. Information such as 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. For that reason, the division finds that 4600 Texas Group did not file for reimbursement in the manner required.

Furthermore, Texas Labor Code §409.0091(s) states that "On or after September 1, 2007, from information provided to a health care insurer before January 1, 2007, under Section 402.084(c-3), the health care insurer may file not later than March 1, 2008." The Division finds that the requestor submitted insufficient documentation to support that a request for reimbursement was filed with the workers' compensation insurance carrier before March 1, 2008. Therefore, 4600 Texas Group, was not eligible to file for reimbursement from the workers' compensation carrier

Conclusion

For each of the reasons stated, the Division finds that the requestor has failed to establish that reimbursement for the disputed charges 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

Signature	Medical Fee Dispute Resolution Officer	November 13, 2014 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.