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
AETNA LIFE INSURANCE COMPANY

Respondent Name
UNITED STATES FIRE INSURANCE CO

MFDR Tracking Number
M4-09-8424-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
May 19, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A data match was performed with the Division of Workers' Compensation and a match was received by MRM on the above worker's compensation case on 11/14/06. Therefore, this case is 'grandfathered' under 409.091(s) [sic] – meaning 409.0091 applies to this case in all regards, *except* the case is exempted from the time limits for filing a request for reimbursement so long as a request for reimbursement or subclaim is filed between September 1, 2007 and March 1, 2008."

Amount in Dispute: $741.08

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 May 26, 2009. 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
March 3, 2004 through July 30, 2004	Professional Services	$741.08	$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.

Issues

1. Did the health care insurer meet the applicable requirements of Texas Labor Code §409.0091?

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 Aetna Life Insurance - a health care insurer as defined by Texas Labor Code §409.0091(a). Medrecovery management and Aetna Life Insurance 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 $741.08 from UNITED STATES FIRE INSURANCE COMPANY - a Texas workers' compensation insurance carrier – hereto after referred to as the carrier. The provisions of Texas Labor Code §409.0091 apply to this request for reimbursement and are hereby considered.

1. Texas Labor Code §409.0091 outlines the process by which a health care insurer as defined by Texas Labor Code §402.084(c-1) may be reimbursed by a workers' compensation insurance carrier. A data match pursuant to Texas Labor Code §402.084(c-3) is therefore required by Texas Labor Code §409.0091(s).

   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 provided a position summary, which indicates that a data match occurred on 11/14/06.
   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred on 11/14/06. Due to the insufficient documentation, the Division is unable to verify that the data match occurred on that date. The Division finds that the requestor is therefore not eligible to file for reimbursement from the workers' compensation insurance carrier under Texas Labor Code §409.0091.

   The Division concludes that the requestor submitted insufficient documentation to support that it met the conditions of §409.0091(s).

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

Signature	Medical Fee Dispute Resolution Officer	April 8, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. The DWC Chief Clerk of Proceedings must receive a completed Request for a Medical Contested Case Hearing (form DWC045A) 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.