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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-12-1809-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Aetna Life Insurance Company asserts that it paid medical service claims totaling $505.84 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: $505.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "MRM, LLC sent the carrier a request for reimbursement on 9/23/2011, but it did not submit proof as to when it received the data match from the Division pursuant to section 402.084 of the Texas Labor Code."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 12, 2010 and November 20, 2010	Professional Services	$505.84	$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 §402.084 sets out the procedures for Record Check; Release of Information.

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 Company - a health care insurer as defined by Texas Labor Code §409.0091(a). Medrecovery management and Aetna Life Insurance Company 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 $505.84 from NEW HAMPSHIRE INSURANCE CO - 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.

   The requestor alleges that it received a data match pursuant to Texas Labor Code §402.084(c-3) from the Division on 8/16/2011. 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 8/16/2011.
   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred on 8/16/2011. 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.

   Texas Labor Code §409.0091(n) states, "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."

   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred on 8/16/2011. The Division is therefore unable to establish that the timeframes outlined above were met by the requestor.

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

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

		April 20, 2016
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. 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.