



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name

Healthcare Subrogation Group

Respondent Name

Safety National Casualty Corporation

MFDR Tracking Number

M4-24-0360-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 12, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 6, 2022	99223, 80048-26, 83605-26, 84145-26, 85025-26, 87040-26, 87077-26, 87147-26, 87186-26, 87205-26, 87641-26, U0002-26, 73630-26-LT, and 99222-57	\$3,203.66	\$0.00
December 7, 2022	99233, 88305-26, 88311-26, 80048-26, 80202-26, 83036-26, 85025-26, 87070-26, 87075-26, 87077-26, 87147-26, 87205-26, 28820-T4, and 01480-QZ-P3		
December 8, 2022	99233, 80048-26, 85025-26, and 99232		
December 9, 2022	99232, 80048-26, 80202-26, and 85025-26		
December 10, 2022	87070-26, 87075-26, 87205-26, 13131-LT, 99232, and 00400-QX-P3		
December 11, 2022	99232, and 99232		
December 12, 2022	E0143-NU, and 99238		
December 21, 2022	99213		
January 4, 2023	99213		
Total		\$3,203.66	\$0.00

Requestor's Position

"... the workers' compensation carrier (hereinafter referred to as "Carrier") had until approximately 10/11/2023 to respond to Subclaimant's request for reimbursement by either issuing payment in full or at a reduced amount, or by denying payment entirely... Carrier failed to issue payment or any response whatsoever. To date, Subclaimant has therefore not received payment or an EOB explaining the basis for denial of the reimbursement request from Carrier. As a result, it is Subclaimant's position that Carrier failed to respond to the reimbursement request within the requisite 90-day period."

Amount in Dispute: \$3,203.66

Respondent's Position

Flahive, Ogden & Latson the representative for Safety National Insurance Company in Austin, was notified of this medical fee dispute on February 7, 2023. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. At present, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. The provisions of Texas Labor Code (TLC) §409.0091 apply to dispute resolution.
2. TLC §409.0091(s) applies to health care insurer when information is provided before January 1, 2007, pursuant to TLC §402.084(c-3).
3. 28 Texas Administrative Code (TAC) §140.8 and 28 TAC §133.307 set out the procedures for health insurers to pursue medical fee dispute resolution.

Denial Reasons

Copies of the explanation of benefits (EOBs) were not provided by either party for consideration in this review.

Issues

1. Did the Requestor file for dispute resolution in accordance with TLC §409.0091 and Texas Administrative Code (TAC) §140.8?
2. Did the Subclaimant file for reimbursement from the workers' compensation insurance carrier in the form and manner prescribed by TLC §409.0091(l)?
3. Did the subclaimant submit sufficient documentation to support that the requirements of 28 TAC §140.8 were met?
4. Is the Subclaimant entitled to reimbursement for the disputed services?

Findings

1. The healthcare insurer (subclaimant) seeks recovery pursuant to §409.0091 from the Texas workers' compensation insurance carrier in the amount of \$3,203.66, for medical services rendered to a Texas workers compensation claimant on December 6, 2022, through January 4, 2023.

TLC §409.0091 effective September 1, 2007, was added by Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 8. The Subclaimant of this medical fee dispute represents a health care insurer as defined by TLC §409.0091(a). TLC §409.0091(c) states that health care paid by a health care insurer may be reimbursable as a medical benefit.

The provisions of TLC §409.0091, and 28 TAC Rule §140.8 apply to this request for reimbursement by a health care insurer and are hereby applied in the Division's determination of whether payment is due in this case.

2. TLC §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."

A review of the Subclaimants reimbursement request letter and DWC Form-026, dated July 13, 2023, found that the Subclaimant requested reimbursement from the workers compensation insurance carrier and received no response regarding the request.

Applicable TLC §409.0091(k)(1) and corresponding 28 TAC §140.8 (h)(3)(A)(i), states 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 carrier fails to respond to a health care insurer's reimbursement request or reduces or denies the requested reimbursement amount for reasons other than lack of medical necessity.

A review of the DWC060, finds that the Division received the medical fee dispute resolution request on October 12, 2023.

The Division finds that the medical fee dispute resolution request was filed with the Division no later than 120 days after the workers' compensation insurance carrier failed to respond to the reimbursement request dated July 13, 2023.

3. 28 TAC §140.8(c)(2), states, "(2) Notice. The health care insurer must give notice of the request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. The notice shall include a copy of the reimbursement request and an explanation that the health care insurer is seeking reimbursement for medical

care costs.”

A review of the documents presented with the medical fee dispute resolution request finds that Subclaimant did not submit any documents to support that the requirements of 28 TAC §140.8(c)(2) were met.

4. A review of the medical fee dispute resolution request finds that the Subclaimant failed to provide the necessary evidence to demonstrate that the injured worker and the medical providers were notified of the request for reimbursement pursuant to §140.8(c)(2).

The Division therefore finds that the Subclaimant has not met the specified rule requirements, and therefore, consideration has not been given to the merits of the request for reimbursement under TLC § 409.0091.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the Subclaimant and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The Division finds the requester has established that reimbursement of \$0.00 is due.

Order

Under TLC §§413.031 and 413.019, the Division has determined the Subclaimant is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	September 27, 2024
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov. The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.