SOAH DOCKET NO. 454-08-0875.M4
TWCC MR NO. M4-07-8148-01

CHILDRESS REGIONAL MEDICAL CENTER, Petitioner	**§**	**BEFORE THE STATE OFFICE**
V.	**§**	**OF**
FEDERATED SERVICE INSURANCE COMPANY, Respondent	**§**	**ADMINISTRATIVE HEARINGS**

DECISION AND ORDER

I. INTRODUCTION

Childress Regional Medical Center (Provider) appealed a Texas Department of Insurance, Division of Workers Compensation, Medical Review Division (MRD) decision that it is not entitled to reimbursement for services provided to an injured worker (Claimant) because it did not submit its bill for payment (the claim) within the time required by statutory and rule law. Provider presented evidence showing that it timely sent the claim to Claimant's employer's workers' compensation insurer, Federated Service Insurance Company (Carrier). However, it also said it could not guarantee that the claim went to Carrier. Carrier presented evidence that it did not receive the claim. Provider had the burden of proof. This decision denies Provider's appeal based on a finding that there was insufficient evidence to conclude that Provider submitted its claim to Carrier in the time required by law.

A hearing convened in this case on February 4, 2008, at the State Office of Administrative Hearings (SOAH) offices in the William P. Clements Building, 300 West 15th Street, Austin, Texas, before the undersigned ALJ. Because of a misunderstanding concerning the need to be present at the hearing, Provider's primary representative Lisa Goodwin did not appear. Provider appeared by telephone through another representative. After both parties presented pre-filed documentary evidence, the hearing was recessed to permit Ms. Goodwin to appear and present Provider's case. The hearing resumed by telephone on February 7, 2008, with all parties present and represented. After the presentation of additional evidence and argument, the hearing closed on that date.

II. DISCUSSION

A. Evidence and Argument

The Texas Labor Code provides as follows at Section 408.027(a):

> **Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER**
>
> (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the day on which the health care services are provided to the insured employee. Failure of the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.[1]

MRD found that Provider did not submit convincing evidence to prove it submitted the claim within legally required time limits.[2] It determined that Provider forfeited its right to reimbursement.[3] Provider filed a timely request for hearing. As the party requesting the hearing, Provider has the burden of proof.[4]

Claimant underwent surgery on _____, at Provider's facilities after suffering an at-work injury on _____, when he fell off a trailer and broke his hip. He was released on October 11, 2006. Provider's bill for the service was $25,632.50. Ms. Goodwin testified that Provider's computer notes show the claim was sent to Carrier on November 14, 2006, by a former employee. A printout from Provider's computer entitled "Standardized Comments" shows a "contact" on November 14, 2006, and includes Carrier's address.[5] Ms. Goodwin said this shows the claim was printed on that date. She acknowledged that Provider waited several months to follow up on the bill.

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[1] The Division's rules at 28 TEX. ADMIN. CODE (TAC) § 133.20(b) provide that a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

[2] Ex. 1 at 5.

[3] *Id.*

[4] 1 TAC § 155.41(b); 28 TAC § 148.14(a).

[5] Ex. 2 at 12.

Ms. Goodwin conceded that Provider's computer does not show who the claim was sent to or what was done with the claim once it was printed. At one point in her testimony, she said Provider's medical bills show they were sent to Claimant's employer _____, and that is the only evidence she has that the claim was sent to anyone. _____ name is printed on the face of Provider's medical bills for Claimant.[6] Ms. Goodwin then testified that the claim should have gone to Carrier, whose address is on the Standardized Comments on the computer printout. She said usually a claim goes to the insurer rather than the employer. She then said the claim was probably sent to both Carrier and _____, but acknowledged there is no evidence the bills were sent to Carrier prior to May 2007. She testified she cannot guarantee where the claim was sent, but maintained that Provider performed the services in good faith and believes it should be paid.

In response to a telephone inquiry, Carrier's employee Lori Hatch advised Provider on May 17, 2007, that Carrier had not received the claim.[7] She wrote, "We rec'd lots of dates around that [time], but not those dates."[8] Ms. Hatch wrote on July 30, 2007, that she contacted Carrier's insured (_____) and was told it never received a copy of the claim.[9]

Carrier contended that the preponderant evidence shows the claim was not timely. It asserted that it first received the claim in June 2007 rather than by January 14, 2007, the 95th day after the health care was provided.[10] It said there was no evidence of what Provider did with the claim once it was printed. It contended the medical bills show they were sent to _____.

[6] Ex. 2 at 13-14.

[7] Ex. 2 at 17.

[8] *Id.*

[9] Ex. 2 at 20.

[10] Ex. 2 at 17.

B. Analysis

The ALJ finds that Provider did not carry its burden of proving the claim was sent to Carrier by the 95th day after the date of service, as required by statutory and rule law. Ms. Goodwin could not say for sure that Provider sent the claim to Carrier in a timely fashion, although she did say at one point that Provider's records show the claim was sent to Carrier. Overall, her testimony was uncertain. By contrast, Carrier's notes clearly indicate it did not receive the claim.[11]

III. FINDINGS OF FACT

1. An injured worker (Claimant) underwent surgery on _____, at the facilities of Childress Regional Medical Center (Provider) after suffering an at-work injury on ____, when he fell off a trailer and broke his hip.

2. Claimant was released on October 11, 2006.

3. Provider's bill for services to Claimant was $25,632.50.

4. Provider's computer notes indicate that the bill (the claim) was sent to Federated Service Insurance Company (Carrier) on November 14, 2006, by a former employee of Provider's.

5. Provider is not certain whether the claim was submitted to Carrier, to Claimant's employer, _____, or to both.

6. Provider was not completely certain that the claim was sent to Carrier.

7. Carrier's notes show it received several bills around the time of Provider's services to Claimant, but that it did not receive the claim for services to Claimant.

8. There is insufficient evidence to conclude that Carrier received the claim for payment for services to Claimant not later than the 95th day after the day on which the health care services were provided to Claimant.

9. All parties received not less than 10 days' notice of the date, time, and location of the hearing, a short, plain statement of the matters asserted, and a reference to the applicable statutes and rules involved.

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[11] Even if Ms. Goodwin's testimony is taken to unequivocally indicate that Provider's notes show Provider sent the claim to Carrier, Provider did not carry its burden of proof. Evidence of proper mailing creates a rebuttable presumption of receipt, but the presumption vanishes in the face of contrary evidence that the mailing was not received. *Limestone Construction, Inc. V. Summit Commercial Industrial Properties*, 143 S.W.3d 538, 544-545 (Tex. App.– Austin 2004, no writ).

10. All parties had an opportunity to respond and present evidence and argument on each issue involved in the case.

IV. CONCLUSIONS OF LAW

1. The State Office of Administrative Hearings has jurisdiction over this proceeding, including the authority to issue a decision and order. TEX. LAB. CODE ANN. §413.031(k) and TEX. GOV'T CODE ANN. ch. 2003.

2. Adequate and timely notice of the hearing was provided in accordance with TEX. GOV'T CODE ANN. §§2001.051 and 2001.052.

3. Provider had the burden of proof in this matter. 28 TEX. ADMIN. CODE (TAC) §148.14.

4. In order to receive payment, a health care provider must submit a claim for payment to the insurance carrier not later than the 95th day after the day on which the health care services are provided to the insured employee. TEX. LAB. CODE ANN. § 408.027(a); 28 TAC § 133.20(b).

5. Provider failed to carry its burden of proving that it submitted a claim for payment to Carrier not later than the 95th day after the day on which the health care services were provided to Claimant.

6. Provider's appeal should be denied. TEX. LAB. CODE ANN. § 408.027(a); 28 TAC § 133.20(b).

ORDER

IT IS, THEREFORE, ORDERED that the appeal of Childress Regional Medical Center of the denial by Federated Service Insurance Company of the claim for services provided to Claimant be, and the same is hereby, denied.

SIGNED March 12, 2008.

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JAMES W. NORMAN
ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS