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
WESTLAKE ANESTHESIA GROUP

Respondent Name
NATIONAL SURETY CORP

MFDR Tracking Number
M4-16-1853-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were provided Blue Cross Blue Shield as this patient's carrier. I have attached a copy of the hospital's facesheet for your review. On this facesheet the insurance provided was UHS AND WE CALLED AND THEY WERE NOT THE CARRIER UPON FURTHER CONTACT WITH THE SURGEONS OFFICE THEY PROVIDED FIREMANS FUND AND THE ADDRESS THEY PROVIDED WAS PO BOX 970 O FALLON MD 63366 WHICH WE MAILED THE CLAIM TO ON 6-3-2015. UPON CALLIND FIREMANS FUND ON 9/23/2015 WE WERE INFORMED THAT WAS NO LONGER THE CORRECT ADDRESS BUT CLAIM NEEDED TO BE MAILED TO PO BOX 740174 ATLANTA GA. AT THAT TIME WE MAILED THE CLAIM TO THE PO BOX 740174 ATLANTA GA."

Amount in Dispute: $700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs…The health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later then the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2015	CPT Code 01936-QZ Anesthesia Services	$700.00	$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 §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written

documentation was sent.

4. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - F286-Date(s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin NO. B-0037-05A
   - 29-The time limit for filing has expired.

Issues

Does the disputed bill meet exception for filing timely? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the disputed anesthesia services based upon reason codes "F286 and 29."

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by 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.'

Texas Labor Code §408.0272(b)(1) states "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title."

28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

The disputed date of service is April 22, 2015. The requestor indicated in the position summary "We were provided Blue Cross Blue Shield as this patient's carrier. I have attached a copy of the hospital's facesheet for your review. On this facesheet the insurance provided was UHS AND WE CALLED AND THEY WERE NOT THE CARRIER UPON FURTHER CONTACT WITH THE SURGEONS OFFICE THEY PROVIDED FIREMANS FUND AND THE ADDRESS THEY PROVIDED WAS PO BOX 970 O FALLON MD 63366 WHICH WE MAILED THE CLAIM TO ON 6-3-2015. UPON CALLIND FIREMANS FUND ON 9/23/2015 WE WERE INFORMED THAT WAS NO LONGER THE CORRECT ADDRESS."

The Division reviewed the submitted documentation and finds the following:

- The requestor noted that the hospital provided them with the incorrect insurance carrier that is supported by the attached hospital's facesheet. The hospital's facesheet was not submitted for review.
- The requestor noted that they called UHS and found out that they were not the carrier. Documentation to support when the contact to UHS was made was not submitted for review.
- The requestor also stated that they contacted the surgeons office and they were provided information regarding insurance coverage through Firemans Fund Insurance. The requestor did not submit documentation when this contact took place.
- The requestor indicated that a claim was mailed to Firemans Fund Insurance on June 3, 2015. In support of the position, the requestor submitted a letter initially dated June 3, 2015, then scratched out and dated September 23, 2015. The requestor did not submit any evidence outlined in 28 Texas Administrative Code §102.4(h) to support when the written communication was sent.
- The initial EOB indicates a bill receipt date of September 26, 2015. No documentation was submitted to support when this bill was sent; therefore, per 28 Texas Administrative Code §102.4(h), the date received

minus five days equals September 21, 2015. This date is 152 days after the April 22, 2015 date of service. It is also, 110 days after the June 3, 2015 letter.

The Division concludes that the requestor did not submit any evidence outlined in 28 Texas Administrative Code §102.4(h) to support position that the disputed bill was submitted timely to the insurance carrier in accordance with Texas Labor Code §408.027(a) and Texas Labor Code §408.0272(b)(1).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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

		March 24, 2016
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.