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
ANESTHESIA ALLIANCE OF DALLAS, P.A.

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-2713-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MAY 9, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The face sheet we received indicated the correct insurance carrier was AMERISURE INSURANCE. We billed this carrier and received a denial stating payment denied for o authorization for the procedure…We contacted the surgeon's office and obtained a copy of the authorization letter for this patient's procedure on 8/25/2015. After review of the authorization letter we determined the correct carrier for this patient is Texas Mutual Insurance…We submitted our claim to Texas Mutual as soon as we learned that we received incorrect carrier information."

Amount in Dispute: $427.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 2/29/16 received the bill…The requestor failed to identify the date it learned Texas Mutual was the correct carrier. Further, the requestor failed to provide Texas Mutual with its bill, a copy of the original bill it submitted to Amerisure as required by the Rule above. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2015	CPT Code 01400-AA Anesthesia Services	$427.12	$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 §133.20, effective January 29, 2009, sets out the procedure for healthcare providers submitting medical bills.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written

documentation was sent.

5. The services in dispute were reduced / denied by the respondent with the following reason code:
   - CAC-29-The time limit for filing has expired.
   - 731-Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
   - 891-No additional payment after reconsideration.
   - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - CAC-193-Original payment decision is being maintained, upon review it was determined that this claim was processed properly.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "CAC-29-The time limit for filing has expired."

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."

The requestor supported position that initially the bills were submitted timely to Amerisure Insurance Co. The requestor noted that Amerisure Insurance Co. denied reimbursement based upon a lack of preauthorization. Upon receipt of this denial, the requestor obtained the preauthorization report from the surgeon and found that Texas Mutual Insurance Co. was the correct carrier. The provider did not indicate the date when they received the correct carrier information.

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."

Because the provider did not indicate the date when they received the correct carrier information, the requestor did not support that the claim was submitted timely to Texas Mutual Insurance Co. in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

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

Signature	Medical Fee Dispute Resolution Officer	05/26/2016 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.