



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

Center for Specialty Surgery of Austin

Respondent Name

Texas Mutual Insurance

MFDR Tracking Number

M4-16-2942-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 24, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am writing to provide a corrected claim for the denial of payment on patient (claimant's) account for date of service 11/13/2015. The claim was originally submitted with the incorrect format for the physician's license number. I have made corrections to the claim to clarify the physician's license number for this patient on this date of service."

Amount in Dispute: \$216,858.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester, an ASC, billed Texas Mutual for surgical services performed on the date above. Texas Mutual received the bill on 1/11/16, reviewed the bill, noted the bill was on a UB04 form, and that the license number format was incorrect. Texas Mutual declined to issue payment as a result. The requestor submitted a second bill by fax that Texas Mutual received on 2/18/16. Texas Mutual reviewed the bill, noted the bill was on a UB04 form, and declined to issue payment. The requestor submitted a third bill by fax, which Texas Mutual received on 3/15/16, observed the submission date by the requestor was greater than 95 days from 11/13/15, and declined to issue payment absent timely bill submission. The requestor submitted a fourth bill by fax. Texas Mutual received it on 3/15/16 at 14:56. Texas Mutual reviewed the bill, noted this was a duplicate of the third bill, and declined to issue payment."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2015	63685,64650, 63650 -59, 77003, 95972, 95973	\$216,858.76	\$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for ambulatory surgical center services.
3. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 745 – An ASC must bill on a CMS-1500 with license number
 - 745 – Incorrect license number format billed. Refer to DWC clean claim guides
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
 - 29 – The time limit for filing has expired
 - 731 – Per 133.20(B) provider shall not submit a medial bill later than the 95th day after the date the service
 - 18 – Exact duplicate claim/service

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. The services in dispute are for a surgery performed in an Ambulatory Surgical Center. The insurance carrier denied the disputed service as 745 – “An ASC must bill on a CMS-1500 with license number.” 28 Texas Administrative Code §134.402 (d) states in pertinent part,

For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided...

The Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers 10, states in pertinent part,

If a facility meets the above requirements, it bills the Medicare contractor using the ASC X12 837 professional claim format or, in rare cases, on Form CMS-1500 and is paid the ASC payment amount.

28 Texas Administrative Code §133 (f)(1)(K) states the following,

All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:

(K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

Review of the submitted documentation finds:

- First claim submission on UB - 04 with creation date January 11, 2016
- Second claim submission on UB -04 with creation date February 18, 2016
- Third claim submission on CMS -1500 with creation date March 15, 2016. Information found in box 17 A was “OB-L7549”

This denial reason is supported as Division requirements for claim submission were not met.

The insurance carrier denied the disputed services with claim adjustment reason codes: 29 – “The time limit for filing has expired.” 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.” Texas Labor Code §408.0272(b) provides that:

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; or
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states that "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." 28 Texas Administrative Code §102.4(h) states that:

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.

Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

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

June , 2016
Date

Signature

Director of Medical Fee Dispute Resolution

June , 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 MFDR 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.