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
SUMMIT SURGICAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-5057-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 30, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was denied for timely filing. I initially billed the claim as any other claim on 10/22/2018, and on 11/05/2018 I received a denial from Texas Mutual that says UB-04 bill code in box 4 is incorrect. On the same day 11/5/2018 I spoke with bill review department, I disputed that fact that I was told bill code was incorrect and bill review allowed me to fax the claim to them to be re-reviewed. On February 5, 2019 I finally received a letter from Texas Mutual that say claim should be submitted on a 1500 form. On that same day I resubmitted the claim on a 1500 hcfa form and then on 3/7/2019 I received a denial informing me that my claim is denied for timely filing."

Amount in Dispute: $28,598.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Texas Mutual on 10/30/2018 received an incomplete bill from SIERRA PACIFIC SURGERY CENTER LLC…Texas Mutual returned the bill to SIERRA PACIFIC SURGERY CENTER LLC with an explanation regarding the requirement for submitting a complete bill. The returned letter also indicates the receipt of an incomplete bill does not imply that the complete medical bill was received within the 95-day timeframe, therefore the returned letter from Texas Mutual does not meet the requirement or exception to proof of timely submission. Texas Mutual on 2/11/2019 received the bill."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2018	Ambulatory Surgical Care (ASC) Services for CPT Code 29881-LT	$19,798.58	$0.00
	ASC Services for CPT Code 29876-LT	$8,800.00	$0.00
TOTAL		$28,598.58	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §133.10, effective April 1, 20014, sets out the health care providers billing procedures.
6. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
7. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - 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.

Issues

Does the documentation support requestor's position that the disputed bills were submitted timely?

Findings

1. The requestor provided ASC services in the state of California on October 17, 2018 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was dissatisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The DWC concludes that because the requestor sought the administrative remedy outlined in 28 Texas Administrative Code§133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. The requestor is seeking payment of $28,598.58 for ASC services rendered on October 17, 2018.
3. According to the explanation of benefits, the respondent denied reimbursement for the disputed ASC services based upon reason code "CAC-29-The time limit for filing has expired."
4. To determine if the ASC services are eligible for reimbursement the DWC refers to the following statute:

   - 28 TAC§ 134.402(d) states, "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 with any additions or exceptions specified in this section."

   - Medicare Claims Processing Manual, Publication 100-04, Chapter 14, section 50 titled ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500, effective January 1, 2018 states, "The Place of Service (POS) code is 24 for procedures performed in an ASC. Prior to January 1, 2008, type of Service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate. Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. The contractors shall assign TOS code 'F' to codes billed by specialty 49 for Place of Service 24."

   - 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."

- 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 TAC §133.10(f)(1) states, "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)."
- 28 TAC §133.20(B) states, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation."

- 28 TAC §133.20(g) states "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier."
- 28 TAC §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."

5. Both parties to this dispute submitted documentation for consideration in support of their position. The DWC reviewed the documentation and finds:

    - The date of service in dispute is October 17, 2018.
    - The requestor is an ASC in California.
    - The respondent denied reimbursement for the ASC services based upon timely filing.
    - The requestor submitted a letter from Texas Mutual Insurance Company dated October 30, 2018 that they were unable to process the bill because "Type of bill code # in box 4 is invalid. Please provide a valid and applicable type of bill code in place #."
    - Per Medicare's Claim Processing Manual, Chapter 14, Section 50, ASC are required to bill on the HCFA-1500 form.
    - The requestor wrote that on November 5, 2018 they spoke with the bill review department and were told the bill code was incorrect. The requestor wrote that after the conversation a claim was faxed to the respondent.
    - The requestor wrote that on February 5, 2019 a letter was received from Texas Mutual that informed them the bill should be submitted on a HCFA-1500 form. On that date a bill was sent to Texas Mutual on a HCFA-1500 form.
    - On February 5, 2019, the provider corrected and resubmitted the bill on a HCFA-1500. Per 28 Texas Administrative Code §133.20 a corrected bill is considered as a new bill; therefore, this bill was submitted past the 95 day deadline.

- The documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent within the 95 day deadline.
- The requestor did not sufficiently support that the bill was submitted to the respondent within the 95 day deadline set out in Labor Code §408.027(a) and 28 TAC §133.20(B).
- The respondent's denial of payment based upon timely filing is supported.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that 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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		09/06/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.