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
ECLIPSE SURGICARE

Respondent Name
TRAVELERS INDEMNITY CO OF CONNECTICUT

MFDR Tracking Number
M4-20-0456-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
OCTOBER 21, 2019

REQUESTOR'S POSITION SUMMARY

"After services were successfully rendered, the claim was then submitted to Travelers on 11/26/18 and confirmed as received the same day. Attached you will find a copy of the claim submission history from our clearing house, Waystar, which substantiates these dates. After successful claim submission, we followed up with Travelers and were informed that our claim was denied and considered 'Incomplete' and was deleted from their system citing a lack of provider license number. Travelers has confirmed that they did receive the claim as previously mentioned; however, seeing as they deemed it 'Incomplete', they never issued an EOR/EOB citing the clack of license number on the claim form…our initial attempt to submit the claim through our clearing house was rejected on 11/21/18 citing missing date of injury and provider license number. On 11/23/18, we updated the missing information and the claim passed clearing house edits and was successfully submitted and received by Travelers on 11/26/18…We kindly request that Travelers reprocess this claim to allow for proper reimbursement in accordance with TAC 134.402."

Amount in Dispute: $35,689.88

RESPONDENT'S POSITION SUMMARY

"The Provider contends they timely submitted the billing for the disputed services on 11-26-2018. In support of that contention, they submit a claim history from their electronic billing software. The claim history does not support that the billing was submitted completely or timely. The last entry on the claim history shows that the electronic billing was printed to a paper claim, and then submitted to this Carrier. This is the bill received by the Carrier on 12.-04-2018 via facsimile. That billing was incomplete as it did not contain the Provider's license numbers. A bill return notification was sent to the Provider with the error listed. The complete bill received by the Carrier on 06-25-2019 was the first complete bill received by the Carrier. Please note that the bill submitted on 06-25-2019 has additional license numbers listed at the bottom, and that neither bill submission matches the bill dated 11-14-2018 in the Provider's Request. The Carrier contends the Provider has not submitted appropriate evidence of timely submission of the billing in dispute. The Carrier received the initial complete billing for this date of service by the Provider on 06-25-2019 via facsimile. Based on Rule 102.4, that makes the submission date the same day. As this date is 222 days after the date of service on 11-14-2018, the billing was not timely submitted as required by Rule 133.20."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2018	Ambulatory Surgical Care (ASC) Services for CPT Code 63685	$23,086.03	$0.00
	ASC Services for CPT Code 63650	$6,301.92	$0.00
	ASC Services for CPT Code 63650	$6,301.92	$0.00
	HCPCS Code L8679	$0.00	$0.00
	HCPCS Code L8680	$0.00	$0.00
TOTAL		$35,689.88	$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 (TAC) §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. 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 §133.10, effective April 1, 2014, sets out the health care providers billing procedures.
5. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
6. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

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

Findings

1. The requestor is seeking payment of $35,689.88 for ASC services rendered on November 14, 2018.

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

3. 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."

   - 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."

- 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: (U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');
- 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."

4. 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 November 14, 2018.
    - The respondent denied reimbursement for the ASC services based upon timely filing.
    - The requestor wrote, "On 11/23/18, we updated the missing information and the claim passed clearing house edits and was successfully submitted and received by Travelers on 11/26/18."
    - The requestor submitted a Claim History report that indicates the claim was rejected several times due to missing information. It indicates "Claim has been forwarded to another entity. Paper claim." It does not support a bill was sent to the respondent.
    - The respondent submitted a copy of a letter dated June 6, 2019 notifying provider that bill was incomplete because "AS LICENSE REQUIRED."
    - The respondent wrote "The Carrier received the initial complete billing for this date of service by the Provider on 06-25-2019…222 days after the date of service.
    - 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

		11/19/2019
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.