TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MUELLER SURGERY CENTER LLC

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-0517-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
November 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2021	30465-SG and L8699	$8,660.52	$6,934.20
	Total	$8,660.52	$6,934.20

Requestor's Position

"Please reviewed the attached documentation, it includes a Certification from the American Association for Accreditation Please Surgery Facilities , our certification # is 6391 and this particular certification attached is good from 09/22/2019 to 09/22/2020, due to the restrictions of Covid 19 compliance with many difference companies, The American Association for Accreditation of Ambulatory Surgery Facilities pushed our re-certification until 05/18/2021 as they did with many other surgery centers, so our certification date is still current. Mueller Surgery Center has met the national standards of a CLASS C ambulatory surgery facility in which major surgical procedure can be performed... We now request that you PAY OUR CLAIM, YOUR COMPANY GAVE AN OUT OF NETWORK AUTHORIZATION FOR OUR SURGERY CENTR TO BE USED AND NOW WE WANT PAYMENT FOR THE USE OF OUR FACILITY."

Amount in Dispute: $8,660.52

Requestor's Supplemental Position Statement

"...for cpt code 30465-SG we have been paid on average $5434.20. This is a rate that is fair and reasonable reimbursement base on prior payments received. It is consistent with the criteria of Labor Code 413.011... Now for CPT Code L8699, we are requesting our cost of $1,200 (invoice attached)+ additional 25% to cover cost of administrative work."

Respondent's Position

"Given the fact the Comprehensive ENT Center of Texas is part of the WorkWell Texas network while the Mueller Surgery Center is not, supports the fact the two are separate entities and the ASC is a stand-alone facility. Additionally, if the ASC is part of the clinic or office as required to be exempt from the license requirement, we should see CPT codes that reflect office visits and not just surgical procedure codes, a review of TXM data and DWC data reflect only surgical related CPT codes have been billed. No additional payment."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 TAC §134.1, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. Texas Insurance Code (TIC) Chapter 1305 applies to health care certified networks.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 892 – Facility not licensed as ASC with Texas Health and Human Services.
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- D25 – Approved non network provider for WorkWell, TX Network claimant per rule 1305.153 (C).
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instruction.
- CAC-W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor obtain an out of network referral from the certified network for the services in dispute?
2. Did the requestor obtain preauthorization for the out-of-network treatment?
3. How is reimbursement established in the Texas Workers' Comp System for the disputed services?
4. Has the requestor justified that the payment amount sought is a fair and reasonable rate?
5. Has the respondent justified that the payment is a fair and reasonable rate?
6. Is the Requestor entitled to reimbursement?

Findings

1. The requestor filed this medical fee dispute to the DWC asking for resolution pursuant to 28 TAC §133.307 titled *MDR of Fee Disputes*. The authority of the DWC to apply TLC statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the TIC, Chapter 1305. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   TIC §1305.006 titled *INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE,* states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

   (1) Emergency Care;

   (2) Health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

   (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to §1305.103."

   The requestor therefore has the burden to prove that the condition(s) outlined in the TIC §1305.006 were met to be eligible for dispute resolution. The DWC finds that the requestor submitted a copy of the out-of-network referral. The DWC concludes that the requestor is therefore eligible for review by Medical Fee Dispute Resolution.

2. The requestor submitted a copy of a preauthorization letter issued by Coventry, dated November 25, 2020 and states in part, "Review Recommendation Results: Certified."

   The preauthorization letter further indicates,

   "NETWORK INFORMATION
   Provider of Record: Daniel Leeman MD- Network status
   Rendering Provider/Facility: Mueller Surgery Center, LLC, 3607 Manor Rd., Suite 102, Austin, TX, 78723
   - Mueller Surgery Center, LLC- OON approval on file."

The DWC finds that the requestor obtained preauthorization for the services in dispute. As a result, the disputed services are reviewed pursuant to 28 TAC §134.402.

3. The requestor seeks reimbursement for Ambulatory Surgery Center(ASC) services, rendered on January 22, 2021 in Mueller Surgery Center and billed with place of service code 24 which is defined as Ambulatory Surgery Center. Reimbursement for ASCs is governed by 28 TAC §134.402.

   The insurance carrier denied the services in dispute with reduction code "892 – Facility not licensed as ASC with Texas Health and Human Services."

   28 TAC §134.402(e) states:

   > Regardless of billed amount, reimbursement shall be:
   >
   > (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   >
   > (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantable.
   >
   > (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

   28 TAC §134.402(e)(1) does not apply as no documentation was submitted by either the requestor or the respondent to support a contract that complies with the requirements of Labor Code §413.011. Since there is no contract, the division then looks to whether the maximum allowable reimbursement (MAR) amount under134.402(f) applies as set out in §134.402(e)(2).

   Per 28 TAC §134.402(a)(1) the "Applicability of this rule is as follows: (1) This section applies to facility services…by an ambulatory surgical center(ASC)."

   28 TAC §134.402(b) states in part that "Definitions for words and terms, when used in these sections, shall have the following meanings…(1) 'Ambulatory Surgical Center' means a health care facility appropriately licensed by the Texas Department of State Health Services."

   After review, the division finds that the requestor, Mueller Surgery Center, is not licensed by the Texas Department of State Health Services. Because the requestor is not licensed by the Texas Department of State Health Services, rule 134.402 and subsection(f) of that rule are not applicable to the services in dispute provided by the requestor.

   Because there is no contract and subsection (f) of 28 TAC §134.402 does not apply, reimbursement shall be determined accordance with 28 TAC §134.1.

   28 TAC §134.1 (a) states,

   > (a) Maximum allowable reimbursement (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules."

TLC §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 TAC §134.1 (f) states, "(f) Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

On June 24, 2022, the requestor and respondent were notified that the services in dispute were reimbursable under 28 TAC §134.1 and were invited to submit arguments for what "fair and reasonable" reimbursement would be for the disputed services.

The respondent did not submit a supplemental position summary. The requestor did submit a supplemental response along with documentation, that they deemed was a fair and reasonable reimbursement argument.

4. 28 TAC §133.307(c)(2)(O) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the DWC has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

   The requestor's argument for fair and reasonable reimbursement for the code 30465-SG is as follows:

   "for cpt code 30465-SG we have been paid on average $5434.20. This is a rate that is fair and reasonable reimbursement base on prior payments received. It is consistent with the criteria of Labor Code 413.011."

   Although the requestor did not submit proof of the payments that are claimed to be an average amount of $5434.20 for code 30465, information known to DWC supports that workers' compensation insurance carriers do pay on average approximately that amount for CPT code 30465.

   The requestor's argument for fair and reasonable reimbursement for HCPCs code L8699 is as follows:

   "Now for CPT Code L8699, we are requesting our cost of $1,200 (invoice attached)+ additional 25% to cover cost of administrative work."

The requestor's supplemental response included an invoice showing the price of the implantable as $1200.00. The requestor's argument for cost of the implantable plus an add-on amount to cover administrative cost concurs with DWC's intent as stated in the January 11, 2008 adoption preamble to the current *Hospital Facility Fee Guideline—Inpatient,* Rule §134.404. The preamble states in part:

> Additionally, the Division agrees that there are administrative costs associated with ordering, processing, and maintaining inventory of these surgically implantable devices. These costs are generally addressed in the add-on allowance for separately billed and reimbursed implantables.

Although the quoted preamble is for inpatient hospitals and the requestor is an ambulatory surgical center, the principles behind fair and reasonable reimbursement for implantables is the same.

Review of the submitted documentation finds that:

- The requestor asks to be reimbursed an average payment for same CPT code paid by other worker's compensation carriers.
- The requestor asks to be reimbursed the cost of the implantable plus an add-on allowance for administrative work.
- The respondent issued payment of $0.00 for the disputed services.
- 28 TAC §134.402 does not apply to the services in dispute as DWC has not established a fee guideline for unlicensed ASCs.
- The requestor submitted redacted copies of a payment screen identifying previous payments issued by other worker compensation carriers for same or similar CPT codes. The DWC finds that most insurance carriers found the following as a fair and reasonable reimbursement:

  > "for cpt code 30465-SG we have been paid on average $5434.20. This is a rate that is fair and reasonable reimbursement base on prior payments received. It is consistent with the criteria of Labor Code 413.011... Now for CPT Code L8699, we are requesting our cost of $1,200 (invoice attached) + additional 25% to cover cost of administrative work."

- The DWC finds the requested amount to be consistent with TLC §413.011(d).
- The requestor supported that payment of the average amounts paid by other workers compensation carriers would satisfy the requirements of 28 TAC §134.1, as a result, reimbursement in the amount of $5,434.20 is recommended for CPT Code 30465-SG.
- The requestor supported that cost plus 25% for L8699 is a fair and reasonable reimbursement, as a result, $1,500.00 is recommended.

The request for additional reimbursement is supported. After review of the submitted information, the Division concludes the requestor has discussed, demonstrated, and justified by preponderance of evidence that the payment amount $6,934.20 is a fair and reasonable rate for the disputed services,

5. Because the requestor has met the burden to show that the amount sought in its supplemental position is a fair and reasonable rate of reimbursement, the Division now reviews information presented by the respondent.

   The respondent did not respond to DWC's request for additional arguments concerning what would be considered fair and reasonable reimbursement for the disputed services. DWC finds that the respondent's previous payment of $0.00 is not a fair and reasonable reimbursement.

6. The DWC finds that the requestor is entitled to reimbursement in the amount of $6,934.20. As a result, this amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of $6,934.20 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $6,934.20 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 11, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.