TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
MUELLER SURGERY CENTER LLC

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-22-2331-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
June 26, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 5, 2021	30450-SG, 30465-59-SG, 30520-SG, 30140-SG, and 31267-SG	$34,588.00	$0.00
November 5, 2021	L8699	$3,000.00	$1,531.25
	Total	$34,588.00	$1,531.25

Requestor's Position

"We now request that you PAY OUR CLAIM, YOUR COMPANY GAVE AN OUT OF NETWORK AUTHORIZATION FOR OUR SURGERY CENTER TO BE USED AND NOW WE WANT PAYMENT FOR THE USE OF OUR FACILITY. Please see all the explanations of reviews as proof of timely filing."

Amount in Dispute: $34,588.00

Requestor's Supplemental Position Statement

"I spoke with… in MFDR department, I was told that for this fee dispute TDI need proof of fair and reasonable reimbursement based on prior payments received. I have attached a total of 4 explanations of payments. The average reimbursement is $1531.25. I will also be faxing the additional documents to Texas Department of Insurance."

Requestor's Supplemental Position Statement

"I am attaching the information needed to allow for the payment of L8699. The operative report and the authorization from Texas Mutual is attached as well as an invoice from the Manufacture."

Respondent's Position

"Mueller Surgery Center claims it is exempt from the licensing requirement because the practice is in Dr. Leeman's clinic: Comprehensive ENT Center of Texas, of Texas, though as noted above they are in separate suites, have different names and FEIN's. Additionally, the American Association for Accreditation of Ambulatory Surgery (AAAASF) Facilities has certified the Muller Surgery Center as a Facility that can perform significant surgeries…. 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."

Response Submitted by: Texas Mutual Insurance Company

Respondent's Supplemental Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-16 – Claim/service lacks information or has submission billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instruction.

Issues

1. Did the requestor obtain an out of network referral from the certified network for the services in dispute?
2. What are the services in dispute?
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 provided documentation to support the non-payment of HCPCs code L8699?
6. Is the requestor entitled to reimbursement for HCPCs code L8699?

Findings

1. The requestor filed this medical fee dispute to the DWC requesting 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 has established that the disputed services are eligible for review by Medical Fee Dispute Resolution.

2. The requestor seeks reimbursement for facility charges rendered on November 5, 2021. On January 23, 2023, the requestor and respondent were notified that the services in dispute are 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 submitted a supplemental position summary, indicating in pertinent part, "To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

The insurance submitted an EOBs to support that a payment in the amount of $14,958.67 had been made for the disputed service.

The DWC contacted the requestor to inquire on whether the payment resolved the dispute. The requestor acknowledge receipt of the payment, however they still continue to contest HCPCs code L8699, because the insurance carrier did not reimburse HCPCs code L8699. As a result, the requestor seeks reimbursement in the amount of $3,000.00 for HCPCs code L8699.

Documentation was submitted by the requestor to support what they deemed was a fair and reasonable reimbursement argument. The insurance carrier did not submit documentation to support their fair and reasonable argument. The DWC will evaluate whether the requestor and respondent provided enough evidence to support their claim for a fair and reasonable reimbursement for HCPCs code L8699.

3. The disputed services are Ambulatory Surgery Center(ASC) services, rendered on November 5, 2021 at 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.

   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 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 in 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, 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 January 23, 2023, the requestor and respondent were notified that the services in dispute are reimbursed under 28 TAC §134.1 and were invited to submit arguments for what "fair and reasonable" reimbursement would be for the disputed services.

The requestor submitted documentation to support their argument of what they deemed is a fair and reasonable reimbursement for HCPCs code L8699. The respondent did not provide any supporting evidence for their fair and reasonable argument. The DWC will evaluate whether the requestor provided sufficient documentation to support their fair and reasonable reimbursement for HCPCs code L8699.

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."

   In support of the requestor's argument for fair and reasonable reimbursement of HCPCs code L8699, the requestor submitted four redacted EOBs from different insurance carriers, which average $1,531.25.

   The DWC requested additional documentation, specifically the operative report, because L8699 is not a specified code. The requestor responded and submitted a copy of the, which means that a code that accurately identifies the implant does not exist. The requestor submitted a copy of an invoice for the implant in dispute.

Review of the submitted documentation finds that:

- The requestor seeks reimbursement for HCPCs L8699. In support of their fair and reasonable reimbursement the requestor submitted 4 redacted EOBs, with reimbursement ranging from $1,200 to $1,925, for the same HCPCs code L8699.
- The requestor submitted a copy of an invoice for the L8699 to support that the cost of the implant is $1,500.00.
- The requestor does not request a specific amount for the reimbursement of HCPCs code L8699.
- 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 the same HCPCs code. The DWC finds that most insurance carriers found the following as a fair and reasonable reimbursement. The average reimbursement rate for the disputed services is $1,531.25.
- The requestor does not specify a reimbursement amount for the invoice price of the implant, which is $1,500.00.
- The DWC finds that $1,531.25 to be consistent with TLC §413.011(d).
- The requestor supported that payment of the average amounts paid by other workers compensation carriers and the implant cost, would satisfy the requirements of 28 TAC §134.1.
- The requestor supported that reimbursement in the amount of $1,531.25 is recommended for HCPCs code L8699.

The request for fair and reasonable reimbursement of HCPCs code L8699 is supported. The DWC concludes that the submitted information, has established that payment in the amount of $1,531.25, is a fair and reasonable rate for the reimbursement.

5. The Division now considers the evidence provided by the respondent since the requestor has satisfied its obligation to demonstrate that the sum requested is a fair and reasonable rate of reimbursement.

   The Division finds that the respondent failed to provide any supporting evidence for their fair and reasonable claim of $0.00 regarding HCPCs code L8699. The DWC concludes that the respondent's prior 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 $1,531.25. Therefore, 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 $1,531.25 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 $1,531.25 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 12, 2023
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 managing 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.