



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

ULNA SURGERY CENTER LLC

Respondent Name

AIU INSURANCE COMPANY

MFDR Tracking Number

M4-22-2476-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 20, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 8, 2021	26615	\$66,486.00	\$6,010.17
January 26, 2022	20680	\$9,939.30	\$0.00
Total		\$76,425.30	\$6,010.17

Requestor's Position

"As per insurance; the denial is because our Ambulatory Surgery Center is not licensed by the Texas Department of Health; an ASC located outside the state of Texas must be licensed by the state when providing services to Texas injured workers. There are authorizations approved by the insurance in order for [injured employee] to be treated at our facility. We have tried in multiples occasions to get this issue resolved with insurance as well as with the adjuster but unfortunately nothing has been resolved. Please see attached documentation and help us resolve this matter."

Amount in Dispute: \$76,425.30

Requestor's Supplemental Position

"We accepted AIG's proposed amount for the surgery performed on 1/26/22. Even though it was \$2,966.72 less than the Georgia Worker's Compensation fee schedule. We are proposing AIG to compensate us for the surgery performed on 12/8/21 according to the Georgia Worker's Compensation fee schedule in the amount of \$6,010.17. Since for one surgery we accepted AIG's offered amount per Texas fee schedule, we are asking AIG to reimburse us for the second surgery under the Georgia Worker's Compensation fee schedule making this fair and reasonable for both parties."

Respondent's Position

"The services have been denied on the basis that the ambulator surgical center is not licensed by the Texas Department of Health under the Texas Ambulatory Surgical Center Licensing Act. An ambulatory surgical center located outside the state of Texas must be licensed by that state when providing services to Texas injured workers under the Act."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code [\(TAC\) §133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.203](#) sets out the fee guideline for professional medical services.
4. [28 TAC §134.1](#) sets forth general provisions related to medical reimbursement.
5. [TLC §413.011](#) sets forth provisions regarding reimbursement policies and guidelines.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 2 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- 4 – The Ambulatory Surgery Center is not properly licensed by the Texas Department of Health under the Texas Ambulatory Surgical Center licensing Act. An ASC located outside the state of Texas must be licensed by that state when providing services to Texas injured workers under the act.
- 5 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the requestor an out of state health care provider?
2. Is the requestor seeking additional reimbursement for CPT Code 20680 rendered on January 26, 2022?
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 is a health care provider that rendered medical services in the state of Georgia to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment. The health care provider has requested medical fee dispute resolution under 28 TAC §133.307. Because the requestor has sought the administrative remedy outlined in 28 TAC §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. The requestor sought reimbursement for CPT Code 20680 rendered on January 26, 2022. The requestor states in pertinent part, "DOS was 1/26/22. The CPT Code used was 20680. . . We only received payment of \$2,335.74... We accepted AIG's proposed amount for the surgery performed on 1/26/22. Even though it was \$2,966.72 less than the Georgia Worker's Compensation fee schedule."

The DWC will therefore review CPT Code 26615 rendered on December 8, 2021.

3. The requestor seeks reimbursement for Ambulatory Surgery Center (ASC) services, rendered on December 8, 2021. Reimbursement for ASCs is governed by 28 TAC §134.402.

The insurance carrier denied the services in dispute with reduction code "4 – The Ambulatory Surgery Center is not properly licensed by the Texas Department of Health under the Texas Ambulatory Surgical Center licensing Act. An ASC located outside the state of Texas must be licensed by that state when providing services to Texas injured workers under the act."

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 under 134.402(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, ULNA Surgery Center, LLC, 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.

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, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection 134.1(f).

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 May 12, 2023, 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 CPT code 26615 is as follows:

“...we are asking AIG to reimburse us for the second surgery under the Georgia Worker’s Compensation fee schedule making this fair and reasonable for both parties.”

The requestor’s supplemental response included a copy of the Georgia Workers Compensation fee schedule in support of the sought amount of \$6,010.17. The requestor supports that workers’ compensation insurance carriers in Georgia pay the amount sought for CPT Code 26615.

The DWC finds that the requestors fee reimbursement request would satisfy the requirements of 28 TAC §134.1, and is consistent with the criteria of Labor Code §413.011; ensures that similar procedures provided in similar circumstances receive similar reimbursement; and is based on values assigned for services involving similar work and resource commitments.

As a result, reimbursement in the amount of \$6,010.17 is recommended for CPT Code 26615 rendered on December 8, 2021.

The request for reimbursement is therefore supported. After review of the submitted information, the DWC concludes the requestor has discussed, demonstrated, and justified by preponderance of evidence that the payment amount \$6,010.17 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 DWC 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.

The DWC finds that the requestor is entitled to reimbursement in the amount of \$6,010.17 for CPT Code 26615 rendered on December 8, 2021. 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 \$ 6,010.17 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 \$6,010.17 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	June 13, 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 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 electrónico CompConnection@tdi.texas.gov.