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
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-24-0667-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 17, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 28, 2023	L8699 Prosthetic Implant NOS	$3,000.00	$0.00
	Total	$3,000.00	$0.00

Requestor's Position

"It was attached to the reconsideration sent on 10/11/2023. On 10/19/2023 TASB denied my request for reconsideration of L8699 as 618➔ The Value of this procedure (not a procedure it is a supply code) is packaged into the payment of other services performed on the same date of service. Based on my research of other workers' compensation claims that have paid for CPT Code L8699, the average reimbursement is $2244.89. I have attached copies of those explanations of payments (decision attached}. Please note that the actual first EOB listed is from Texas Association of School Boards. I also included a Stryker invoice showing what we were billed for the Latera Implant."

Amount in Dispute: $3,000.00

Requestor's Supplemental Position Statement

"...I would like to bring it to your attention, according to the prior payment from TASB, eob 1 attached in the fee dispute paperwork, it was $1925.00. Also given the time it took TASB to realize their error, the suggested payment of $1650.40 is a little light. The Mueller Surgery Center is happy to see that nonpayment fault has been accepted. We will wait to see how TDI rule on how much TASB will have to pay based on reasonable and customary guidelines. Base on the proof provided, the average reimbursement is actually $2324.87."

Respondent's Position

"On previous request the service was denied as Global however, we did not receive the Implant Invoice until 10/12/2023. We found that additional is owed at (1) unit per implantable wholesale invoice received. Per your request an additional $1650.00 is owed, including $0.40 accrued interest, totaling $1650.40."

Response Submitted by: TASB Risk Fund

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.

Denial Reasons

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

- 350 – BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 353 – THIS CHARGE WAS REVIEWED ACCORDING TO THE SUBMITTED INVOICE AND DOCUMENTATION.
- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. USAGE: THIS ADJUSTMENT AMOUNT CANNOT EQUAL THE TOTAL SERVICE OR CLAIM CHARGE AMOUNT; AND MUST NOT DUPLICATE PROVIDER ADJUSTMENT AMOUNTS (PAYMENTS AND CONTRACTUAL...
- P13 – PAYMENT REDUCED OR DENIED BASED ON WORKERS' COMPENSATION JURISDICTIONAL REGULATIONS OR PAYMENT POLICIES, USE ONLY IF NO OTHER CODE IS APPLICABLE.
- U03 – THE BILLED SERVICE WAS REVIEWED BY UR AND AUTHORIZED.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What are the services in dispute?
2. How is the reimbursement established in the Texas Workers' Comp System for the disputed services?
3. Has the requestor justified that the payment amount sought is a fair and reasonable rate?
4. Is the requestor entitled to additional reimbursement for HCPCs code L8699?

Findings

1. The requestor seeks reimbursement for HCPCs code L8699 rendered on July 28, 2023.

   The insurance carrier submitted EOBs to support that a payment in the amount of $1,650.40 was issued to the requestor after the filing of the MFDR request.

   The requestor responded to the insurance carrier's MDR response indicating that, "…given the time it took TASB to realize their error, the suggested payment of $1650.40 is a little light… Base[sic] on the proof provided, the average reimbursement is actually $2324.87."

   The requestor also states, "We will wait to see how TDI ruled on how much TASB will have to pay based on reasonable and customary guidelines."

   Documentation was submitted by the requestor to support what they deemed was a fair and reasonable reimbursement. The insurance carrier submitted a position statement indicating "We found that additional is owed at (1) unit per implantable wholesale invoice received." The DWC will determine whether the requestor and respondent provided enough evidence to support their claim for a fair and reasonable reimbursement for HCPCs code L8699.

2. The disputed service is a prosthetic implant not otherwise specified billed with CPT code L8699 and rendered on July 28, 2023. The disputed service was rendered in an Ambulatory Surgery Center (ASC), 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 further 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, 28 TAC §134.402 and subsection (f) of that rule is not applicable to the service 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.

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."

3. 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 fair and reasonable argument for reimbursement of HCPCs code L8699, the requestor submitted five redacted EOBs from different insurance carriers, which average $2,324.87.

   A review of the operative report documents that the requestor billed for a polymer implant under CPT code L8699, a non-specified code. The requestor submitted a copy of an invoice for the implant in dispute.

A review of the submitted documentation finds the following:

- The requestor seeks reimbursement for HCPCS L8699. In support of their fair and reasonable reimbursement, the requestor submitted five redacted EOBs, with reimbursement ranging from $1,500 to $3,000 for the same HCPCS code L8699.
- The requestor submitted a copy of an invoice for "Latera System 1 pack, quantity 2, $1,500 x 2 = $3,000 to support the cost of the implant.
- The requestor in their response requested $2,324.87 for HCPCs code L8699 via email on December 7, 2023. In their DWC060, the requestor is asking for $3,000.00, the billed amount for L8799.
- The respondent issued a payment after the submission of the DWC060 in the amount of $1,650.40.
- 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 HCPC code.
- The requestor does not ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not base the requested reimbursement amount on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments.

Although the requestor submitted redacted EOBs in support of payment for L8699, the requestor did not submit documentation to support that the disputed service, a polymer implant billed under HCPCS code L8699, was for the same or similar service.

The request for fair and reasonable reimbursement for HCPCs with code L8699 is not supported. The DWC concludes that the submitted information has not established that payment in the amount of $3,000.00 is a fair and reasonable rate of reimbursement.

4. The DWC finds that the requestor is not entitled to additional reimbursement for the disputed service.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		March 13, 2024
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, 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.