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**
Zurich American Insurance Company

**MFDR Tracking Number**
M4-25-0792-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
December 9, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| January 5, 2024 | 17999 | $2,327.75 | $0.00 |
| January 5, 2024 | 0232T | $269.57 | $0.00 |
| April 19, 2024 | 17999 | $2,327.75 | $0.00 |
| April 19, 2024 | 0232T | $269.57 | $0.00 |
| May 16, 2024 | 17999 | $2,327.75 | $0.00 |
| May 16, 2024 | 0232T | $269.57 | $0.00 |
| June 20, 2024 | 17999 | $2,327.75 | $0.00 |
| June 20, 2024 | 0232T | $269.57 | $0.00 |
| | **Total** | $10,875.91 ($10,389.28) | $0.00 |

## Requestor's Position

"Our facility claim has not been paid for .... date of service, 01/05/2024. CPT Code 17999-SG & 0232T-SG have been denied as it is not allowed in this place of service and there is no allowance per Medicare guidelines. CPT CODE 17999 (Microneedling upper lip) for $5000 was authorized to break up scar tissue. CPT Codes 0232T is the platelet rich plasma is then used to apply after Microneedling is complete, the patient's plasma which contains stem cells helps with regeneration of healthy tissues. Both of these services are normally considered to be cosmetics and there is no Medicare allowable because Medicare doesn't pay for cosmetic procedures. We used an unlisted procedure code for the Microneedling because there isn't a better CPT code to

use. So yes, the service is not allowable under the Medicare ASC fee schedule, however Zurich approved …. the procedure to treat scarring that was a direct result of a work comp Injury.

We have previously been paid by Zurich for this type of service. I have reviewed our billing records since 11/2020, and I have found that our average reimbursement for CPT Code 17999 is $2327.75 (excel spreadsheet and eobs are attached). I have used the Ambulatory surgical center fee guidelines to figure out what the reimbursement for CPT code 0232T should be $269.57. We are just seeking fair reimbursement. The claims have been appealed without success. We are now seeking assistance from the Texas Department of Insurance to Intervene and help us get Zurich to understand that they are incorrect with their denial reasons and that will find that these codes are payable."

**Amount in Dispute:** $10,875.91

## Respondents' Position

"We are attaching a copy of the carrier's EOBs in response to each of the dates of service.
It is the carrier's position that the provider is not entitled to payment. This is further explained on the EOBs. The provider is not entitled to any reimbursement."

**Response Submitted by:** Flahive, Ogen & Latson

## 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 set out the medical reimbursement policies.
4. Texas Labor Code (TLC) §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Denial Reasons

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

Date of service April 19, 2024:

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
- 59 - Processed based on multiple or concurrent procedure rules.

Dates of service January 5, 2024, May 16, 2024, and June 20, 2024:

- P12- Worker compensation jurisdictional fee schedule adjustment.
- 58 - Treatment was deemed by the payer to have been rendered in any inappropriate or invalid place of service.
- 97 - The benefit for this service is included in the payment allowance for another service/procedure that has been previously adjudicated.
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18 – Exact duplicate claim/service.

Issues

1. Did the insurance carrier issue payment for disputed date of service April 19, 2024, after the submission of the Medical Fee Dispute Resolution request?
2. Is the requestor entitled to reimbursement for procedure codes 0232T and 17999?

Findings

1. The requestor seeks reimbursement for procedure codes 0232T, and 17999 rendered on April 19, 2024. On this date of service, the requestor billed procedure code 0232T in the amount of $5,000.00, and 17999 in the amount of $5,000.00. The insurance carrier submitted EOBs to support that a payment in the amount of $7,500.00, for this date of service was issued to the requestor after the filing of the MFDR request.

   The division finds that insurance carrier issued a payment under payment ID 8700397xxx, in the amount of $7,500.00 for disputed procedure codes 0232T, and 17999 provided on April 19, 2024.

   The requestor seeks reimbursement in the amount of $5,000.00 for procedure code 17999. The insurance carrier has issued a payment of $5,000.00; therefore, additional payment is not recommended.

   The requestor seeks reimbursement in the amount of $269.57 for procedure code 0232T. The insurance carrier has issued a payment in the amount of $2,500.00; therefore, additional payment is not recommended.

   The division finds that because the disputed services provided on April 19, 2024, were reimbursed by the insurance carrier, after the submission of the Medical Fee Dispute Resolution request, the requestor is not entitled to additional payment.

2. The requestor seeks reimbursement for procedure codes 0232T, and 17999 rendered on January 5, 2024, May 16, 2024, and June 20, 2024.

The disputed services were billed with procedure codes 0232T, and 17999 and rendered at Mueller Surgery Center an Ambulatory Surgery Center (ASC), billed with place of service code 24 defined as Ambulatory Surgery Center. Reimbursement for ASCs is governed by 28 TAC §134.402.

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."

Mueller Surgery Center is not licensed by the Texas Department of State Health Services, according to an examination of the documents filed. Because the requester is not licensed by the Texas Department of State Health Services, 28 TAC §134.402 paragraph (f) is not relevant to the services in dispute.

28 TAC §134.402 does not apply to the services in dispute, as DWC has not established a fee guideline for unlicensed ASCs. 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:

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 procedure codes 0232T, and 17999, the requestor submitted copies of ledgers where the insurance carrier paid 100% of billed charges. Billed charges and historical reimbursement rates, by themselves, do not show compliance with the factors identified in Section 413.011 of the Act for determining a fair and reasonable reimbursement. The amounts that other carriers have paid may be some indication of what a fair and reasonable amount might be, but by itself that information is not dispositive under the statutory guidelines. A health care provider's charges are not evidence of a fair and reasonable rate or of what insurance companies are paying for the same or similar services. Unquestioning payment of a health care provider's billed charge would leave the determination of the payment amount in the provider's own hands, contrary to the objective of effective cost control and the standard not to pay more than for similar treatment of an injured individual of equivalent standard of living, both in Texas Labor Code § 413.011(d).

The requester also included copies of EOBs in which other insurance carriers issued payments at a reduced rate. The division finds that the requestor has not based the reimbursement amount on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments.

SOAH similarly rejected evidence of other payments to providers, alone, as satisfying the fairness and reasonableness factor of effective medical cost control. Neither Provider's evidence of its billed charges, nor Provider's evidence of other carriers' payments suffices to find Provider's requested reimbursement at 100 percent of Provider's billed charges or reduced payments to be fair and reasonable. Therefore, Provider failed to show by a preponderance of the evidence that the reimbursement amount it seeks is fair and reasonable.

The division concludes that the requestor has not submitted sufficient documentation to support that fair and reasonable reimbursement is warranted for the disputed services.

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 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | April 28, 2025 |
| 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.