TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER

Respondent Name
CHUBB INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-18-0544

Carrier's Austin Representative
Box Number 17

MFDR Date Received
OCTOBER 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim not paid according to the 2017 Texas Ambulatory Surgical Center Fee Schedule."

Amount in Dispute: $121.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel will maintain payment was correctly issued to the requestor in accordance with division rules in effect at the time services were rendered."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2017	Ambulatory Surgical Care Services CPT Code 25609-RT	$121.73	$0.00
	Ambulatory Surgical Care Services CPT Code 25280-RT	$0.00	$0.00
TOTAL		$121.73	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving

medical fee disputes.

2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - RD7-Mutliple procedure/1st procedure.
   - W3-Appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services for CPT code 25609-RT?

Findings

1. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
2. 28 Texas Administrative Code §134.402(b) (6) states, "Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "Medicare payment policy' means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."
3. 28 Texas Administrative Code §134.402(d) states "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs."
4. CPT code 25609 is described as "Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments."

   Per ADDENDUM AA, CPT code 25609 is a device intensive procedure and is subject to the multiple procedure rule discounting.
5. The requestor did not request separate reimbursement for the implantables; therefore, Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) applies to this dispute.

   Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."
6. Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) establishes reimbursement for device intensive procedure code 25609 as a two step process:

   Step 1 calculating the device portion of the procedure:

   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 25609 for CY 2017 = $5,221.57.

   This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 44.22% = $2,308.97.

   Step 2 calculating the service portion of the procedure:

   Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25609 is $3,679.62.

   Per the Medicare fully implemented ASC reimbursement rate of $3,679.02 is divided by 2 = $1,839.81.

This number multiplied by the City Wage Index for Carrollton, TX $1,839.81 X 0.9895 = $1,820.49.

The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,660.30.

The service portion is found by taking the national adjusted rate of $3,660.30 minus the device portion of $2,308.97 = $1,351.33.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $1,351.33 X 235% = $3,175.63.

The MAR is determined by adding the sum of the reimbursement for the device portion of $2,308.98 + the geographically adjusted service portion of $3,175.63 = $5,484.60.

The MAR is calculated to be $5,484.60 and the insurance carrier paid $5,484.58, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Greg Arendt	10/18/2018
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.