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

GENERAL INFORMATION

Requestor Name
Denton Surgicare Ltd

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-18-1880

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 16, 2018

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $566.73

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute submitted by the requestor Denton Surgicare, the Office performed an in-depth review of the disputed charges for date of service 10/19/2017 and determined that payment has been made in accordance with the Division's rules and payment policies under Rule §134.402 Titled Ambulatory Surgical Center Fee Guideline."

Response submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2017	25608	$566.73	$0.00

FINDINGS AND DECISION

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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for ambulatory surgical center services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - P12 – Workers' compensation jurisdictional fee schedule adjustment
    - 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines
    - 983 – Charge for this procedure exceeds Medicare ASC schedule allowance

Issues

1. How it the applicable fee guideline calculated?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement for CPT Code 25608 rendered October 19, 2017. The insurance carrier reduced the service in dispute based on the Medicare and Division fee guidelines. The Medicare and Division fee guidelines are as follows.

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.

The applicable Medicare payment policy is at www.cms.gov, Medicare Claims Processing Manual, Chapter 14, Section 40.2 that states in pertinent part,

For dates of service on or after January 1, 2008, the ASC payment rates are ***geographically wage adjusted based on the wage index for the CBSA.*** *Beginning January 1, 2008 CMS calculates and makes available to the contractors CBSA-specific ASC payment rates for services subject to geographic adjustment. The wage index values for urban and rural areas that CMS applies to all non-acute providers are used in the calculation of the ASC wage adjusted payment rates. With the implementation of the ASC revised payment system, the labor related portion of the payment rate is 50 percent and the remaining non-labor related portion is 50 percent.*

The applicable DWC fee guideline is found at 134.402 (f)(2)(A) states in pertinent part,

> 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;

Review of Addendum AA found at www.cms.gov, found CPT Code 25608 has a payment indicator of J8 – "Device-intensive procedure; paid at adjusted rate." Based on the above, the maximum allowable reimbursement is calculated in two parts,

Part 1 – Calculating the device portion

OPPS Addendum B payment rate	APC Offset percentage	Total
$5,221.57	42.55%	$5,221.57 x 42.55% = $2,221.78

Part 2 – Calculating the service portion of the procedure

CPT Code	Payment Rate for Oct 2017	Non - Labor Portion (Payment Rate at 50%)	Labor Portion (Payment Rate at 50% x 2017 Wage Index Adjustment for Denton 0.9895)	Labor related portion plus remaining non-labor portion = Medicare ASC facility reimbursement amount	Service Portion	Service Portion x DWC payment adjustment	MAR = sum of device portion and Adjusted ASC payment
25608	$3,636.38	$3,636.38 ÷ 2 = $1,818.18	$1,818.18 x 0.9895 = $1,799.09	$1,818.18 + $1,799.09 = $3,617.27	$3,617.27 - $2,221.78 = $1,395.49	$1,395.49 x 235% = $3,279.40	$2,221.78 + $3,279.40 = $5,501.18

2. The total allowable reimbursement for the services in dispute is $5,501.18. The amount previously paid by the insurance carrier is $5,501.23. No additional reimbursement 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 §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 20, 2018 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.