



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NW SURGERY CENTER RED OAK

Respondent Name

SENTRY CASUALTY CO

MFDR Tracking Number

M4-19-0923-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

OCTOBER 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The claim is underpaid by \$664.04 not \$797.04 that was originally requested."

Amount in Dispute: \$797.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have verified that this bill paid correctly according to the Texas Fee Schedule."

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	Ambulatory Surgical Care Services CPT Code 25607	\$3,891.52	\$2,871.35
	Ambulatory Surgical Care Services CPT Code 20900	\$63.16	\$63.08
	Ambulatory Surgical Care Services CPT Code 25320	<\$3,031.32>	<3,031.40>
	HCPCS Code Q4100	\$0.00	\$0.00
	HCPCS Code C1713	\$0.00	\$0.00
TOTAL		\$797.04	\$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, 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:
 - 615-Payment for this service has been reduced according to the Medicare multiple surgery guidelines.
 - 350-Bill has been identified as a request for reconsideration or appeal.
 - A90-This charge was reimbursed in accordance to the Texas medical fee guideline.
 - 662-Separate payment for this service is not warranted as the service is an integral part of the surgical procedure package.
 - 618-This item or service is not covered or payable under the Medicare outpatient fee schedule.
 - 59-Processed based on multiple or concurrent procedure rules.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - P63-Any reduction is in accordance with your AETNA contract.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on March 14, 2018?

Findings

1. The fee guideline for ASC services is found at 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 25607 is described as "Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation"
5. Per ADDENDUM AA, CPT code 25607 is a device intensive procedure.
6. Division rule at 28 TAC §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."
7. 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."

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.

8. Division rule at 28 TAC §134.402(f)(2)(A)(i)(ii) reimbursement for device intensive procedure code 25607 is 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 25607 for CY 2018 = \$5,606.42.

This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 42.74% = \$2,396.18.

Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25607 is \$3,820.11.

Per the Medicare fully implemented ASC reimbursement rate of \$3,820.11 is divided by 2 = \$1,910.05.

This number multiplied by the City Wage Index for Houston, TX $\$1,910.05 \times 0.9750 = \$1,862.29$.

The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$3,772.34.

The service portion is found by taking the national adjusted rate of \$3,772.34 minus the device portion of \$2,396.18 = \$1,376.16.

Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $\$1,376.16 \times 235\% = \$3,233.97$.

The MAR is determined by adding the sum of the reimbursement for the device portion of \$3,233.97 + the service portion of \$2,396.18 = \$5,630.15. The insurance carrier paid \$2,758.80. As a result, the difference between the MAR and amount paid of \$2,871.35 is recommended.

9. The requestor is seeking additional reimbursement of \$63.16 for CPT code 20900.
10. CPT code 20900 is defined as "Bone graft, any donor area; minor or small (eg, dowel or button)."
11. Per ADDENDUM AA, CPT code 20900 is a non-device intensive procedure.
12. 28 Texas Administrative Code §134.402(f)(1)(B) 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: (1) Reimbursement for non-device intensive procedures shall be: A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.

13. Division rule at 28 TAC §134.402(f)(1)(B) reimbursement for non-device intensive procedure code 20900 is:

The Medicare fully implemented ASC reimbursement for code 20900 CY 2018 is \$2,721.37.

The Medicare fully implemented ASC reimbursement rate of \$2,721.37 is divided by 2 = \$1,360.66.

This number multiplied by the City Wage Index for Houston, Texas is $\$1,360.66 \times 0.9750 = \$1,326.64$.

Add these two together $\$1,326.64 + \$1,360.66 = \$2,687.30$.

To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$6,315.15. This code is subject to multiple procedure rule discounting of 50% = \$3,157.57. The respondent paid \$3,094.49. The requestor is due the difference between MAR and paid of \$63.08.

14. The requestor indicated that they were over-paid \$3,031.32 for code 25320.

15. CPT code 25320 is defined as “Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability.”
16. Per ADDENDUM AA, CPT code 25320 is a non-device intensive procedure.
17. Division rule at 28 TAC §134.402(f)(1)(B) reimbursement for non-device intensive procedure code 25320 is:
18. The Medicare fully implemented ASC reimbursement for code 25320 CY 2018 is \$2,721.37.
19. The Medicare fully implemented ASC reimbursement rate of \$2,721.37 is divided by 2 = \$1,360.66.
20. This number multiplied by the City Wage Index for Houston, Texas is \$1,360.66 X 0.9750 = \$1,326.64.
21. Add these two together \$1,326.64 + \$1,360.66 = \$2,687.30.
22. To determine the MAR multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$6,315.15. This code is subject to multiple procedure rule discounting of 50% = \$3,157.57. The respondent paid \$6,188.97. The difference between MAR and paid is \$3,031.40.
23. The division finds the MAR for ASC services rendered on March 14, 2018 is \$11,945.29. The respondent paid \$12,042.26. As a result, additional reimbursement is not 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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/20/2018 Date
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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.