



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

BAYLOR SURGICARE AT OAKMONT

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-19-3892-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

APRIL 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The procedure was billed is considered a device intensive procedure. According to the 2018 ASC Work Comp CASE CALCULATOR for Texas, the total allowed amount for this claim should have been \$6,600.25."

Amount in Dispute: \$1,155.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "no additional reimbursement is owed because Requestor was correctly paid in accordance with the fee guidelines."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 29, 2018, Ambulatory Surgical Care (ASCs) Services CPT Code 25609-RT, \$1,155.34, \$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:
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 983-Charge for this procedure exceeds Medicare ASC schedule allowance.

- 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3-Additional payment made on appeal/reconsideration.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

## Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on August 29, 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 25609 is described as "Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments."
5. Per ADDENDUM AA, CPT code 25609 is a device intensive procedure.
6. Division rule at 28 TAC §134.402(f)(2)(B)(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: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:
  - (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or \$1,000 per billed item add-on, whichever is less, but not to exceed \$2,000 in add-on's per admission; and
  - (ii) the ASC service portion multiplied by 235 percent."
7. Division rule at 28 TAC §134.402(f)(2)(B)(i)(ii) reimbursement for device intensive procedure code 25609 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 25609 for CY 2018 = \$5,606.03.

This number multiplied by the device dependent APC offset percentage for National Hospital OPPS reimbursement of 44.05 % = \$2,469.46.

Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25609 is \$3,855.65.

Per the Medicare fully implemented ASC reimbursement rate of \$3,855.65 is divided by 2 = \$1,927.82.  
This number multiplied by the City Wage Index for Fort Worth, TX is 0.9590 = \$1,848.77.  
The sum of these two is the geographically adjusted Medicare ASC reimbursement = \$3,776.59.  
The service portion is found by taking the national adjusted rate of \$3,776.59 minus the device portion of \$2,469.46 = \$1,307.13.  
Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment \$1,307.13 X 235% = \$3,071.75.  
The MAR is found by adding the device portion to the service portion = \$5,541.21.  
The respondent paid \$5,444.91. 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

5/16/2019  
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.**