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
FEDEX GROUND PACKAGE SYSTEM INC

MFDR Tracking Number
M4-19-4146-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been process incorrectly. This is a device intensive procedure. The correct allowable amount for procedure code 25609 is $6,729.98."

Amount in Dispute: $1,154.07

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has identified a CPT code reimbursement that it is seeking reimbursement for as 25609. We would point out that the provider provided two services on February 6, 2019. The other service was under CPT code 64415, which the carrier reimbursed the provider the amount of $456.08. With respect to CPT code 25609, the carrier initially reimbursed the provider the amount of $2,185.73. The carrier subsequently reimbursed the provider the amount of $3,390.16…The provider is not entitled to additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2019	Ambulatory Surgical Care Services CPT Code 25609	$1,154.07	$59.20

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.
   - 4063-Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
   - 1002-Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.
   - 18-Exact duplicate claim/service.
   - 247-A payment or denial has already been recommended for this service.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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 February 6, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,154.07 for ambulatory surgical care services rendered to the injured worker on February 6, 2019. The insurance carrier paid $5,575.91 for the disputed services based upon the fee guideline.

2. The fee guidelines for disputed services is found in 28 Texas Administrative Code §134.402.

3. 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.

4. 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.

   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. To determine the appropriate reimbursement for CPT code 25609 the division refers to 28 Texas Administrative Code §134.402(f).

   28 Texas Administrative Code §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."

Per ADDENDUM AA, CPT codes 25609 is a device intensive procedure.

The following formula was used to calculate the MAR:

- 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 2019 = $5,699.59

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25609 for CY 2019 is 44.58%

  Multiply these two = $2,540.87

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25609 for CY 2019 is $3,915.73.
  This number is divided by 2 = $1,957.86.
  This number multiplied by the City Wage Index for Fort Worth, TX of 0.9703 = $1,899.71.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,857.57.
  The service portion is found by taking the geographically adjusted rate of $3,857.57 minus the device portion of $2,540.87 = $1,316.70.

  Multiply the service portion by DWC payment adjustment of 235% = $3,094.24.

The MAR is determined by adding the sum of the reimbursement for the device portion of $2,540.87 + the service portion of $3,094.24 = $5,635.11. The insurance carrier paid $5,575.91. As a result, the difference between the MAR and amount paid of $59.20 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $59.20.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $59.20, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		07/18/2019
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.