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
TEXAS SURGICAL CENTER

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-4753-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JULY 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2019 Texas Workers Compensation Fee Schedule and Guidelines FOR Ambulatory Surgical Centers."

Amount in Dispute: $2,793.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "MIDLAND TEXAS SURGICAL CENTER was issued payment in accordance with the ASC wc fee schedule. CPT code 25515 is a device intensive code identified by the status indicator 'J8'. Payment methodology for device intensive procedures, when the provides does not request separate reimbursement for implants is 235% of the service portion of Medicare's geographically adjusted fully implemented rate, plus Medicare device portion…CPT code 25515 was paid $3,746.65 as recommended, the device portion $1,840.60 is paid on line 2 cpt code C1713 $1840.60. No additional payment due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2019	Ambulatory Surgical Care Services (ASC) CPT Code 25515	$2,793.01	$0.00
	ASC Services HCPCS Code C1713	$0.00	$0.00
TOTAL		$2,793.01	$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. 28 Texas Administrative Code §133.10, sets out the required health care provider billing procedures.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 763-Paid per ASC FC at 235%: Implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(G).
   - 878-Appeal(Request for reconsideration) previously processed. Refer to rule 133.250(H).
   - CAC-18-Exact duplicate claim/service.
   - W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor due additional reimbursement for ASC services rendered on January 4, 2019?

Findings

1. On the disputed date of service, the requestor billed $9,196.00 for CPT code 25515 and $438.15 for code C1713. The respondent paid $3,746.65 for code 25515 and $1,840.60 for C1713. The requestor is seeking additional reimbursement of $2,793.01 for code 25515.
2. The fee guideline for ASC services is found in 28 Texas Administrative Code §134.402.
   - 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.

   - 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 25515 is described as "Open treatment of radial shaft fracture, includes internal fixation, when performed."

   HCPCS code C1713 is described as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."
3. Is the respondent's basis for payment of code C1713 supported?

   According to the submitted explanation of benefits, the respondent paid$1,840.60 for code C1713 based upon "763-Paid per ASC FC at 235%: Implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402(G)." The respondent wrote, "Payment methodology for device intensive procedures, when the provides does not request separate reimbursement for implants is 235% of the

service portion of Medicare's geographically adjusted fully implemented rate, plus Medicare device portion."

The division finds the respondent position summary and explanation on EOB contradict the payment for code C1713.

4. Did the requestor seek separate reimbursement for code C1713?

28 Texas Administrative Code §133.10(f)(1)(W) states,

> All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1)The following data content or data elements are required for a complete professional or non-institutional medical bill related to Texas workers' compensation health care: (W) supplemental information (shaded portion of CMS-1500/field 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line.

Based upon the review of the submitted documentation and above referenced statute, the division finds:

- A review of the submitted medical bill indicates "NTE*ADD*Device 100% of CMS +235% service."
- The requestor billed and was paid separately for the implantables.
- The requestor did not indicate on the medical bill on fields 24d-24h a request for separate reimbursement for the implantables as required by 28 Texas Administrative Code §133.10(f)(1)(W).
- The requestor is not due separate reimbursement for HCPCS code C1713 due to billing errors.

5. What is the appropriate reimbursement for ASC services rendered on January 4, 2019?

Per ADDENDUM AA, CPT codes 25515 is a device intensive procedure.

To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.402(f)(2)(A).

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."

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 25515 for CY 2019 = $5,606.42

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25515 for CY 2019 is 33.03%

Multiply these two = $1,851.80

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare fully implemented ASC reimbursement rate for code 25515 for CY 2019 is $3,636.76.

  This number is divided by 2 = $1,818.38.

  This number multiplied by the City Wage Index for Midland, TX of 0.8890 = $1,616.53.

  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,434.91.

  The service portion is found by taking the geographically adjusted rate of $3,434.91 minus the device portion of $1,851.80 = -$1,583.11.

  Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment of 235% = $3,720.30.

Step 3 the MAR is determined by adding the sum of the reimbursement for the device portion + the service portion = $5,572.10.

The total due for ASC services rendered on January 4, 2019 is $5,572.10. The insurance carrier paid $5,587.25. 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

		08/08/2019
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 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.