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
METROCREST SURGERY CENTER

Respondent Name
TRAVELERS CASUALTY INS CO OF AMERICA

MFDR Tracking Number
M4-19-4864-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JULY 15, 2019

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: $1,120.92

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2019	Ambulatory Surgical Care Services (ASCs) CPT Code 25609-RT	$1,120.92	$63.83
	ASCs CPT Code 29848	$0.00	$0.00
TOTAL		$1,120.92	$63.83

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 (DWC).

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.
   - 4123-Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
   - 6000-Request for reconsideration.
   - W3-Reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on March 4, 2019?

Findings

1. The Austin carrier representative for Travelers Casualty Ins Co Of America is The Travelers Companies. The Travelers Companies acknowledged receipt of the copy of this medical fee dispute on July 24, 2019. 28 TAC §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative; therefore, this decision is based on the available information as authorized under §133.307(d)(1).
2. The requestor is seeking medical fee dispute resolution in the amount of $1,120.92 for ASC services rendered to the injured worker on March 4, 2019. The insurance carrier paid $5,649.04 for the disputed services based upon the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.
4. 28 TAC §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.

5. 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, 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."

6. To determine the appropriate reimbursement for CPT code 25609 the DWC refers to 28 TAC §134.402(f).

   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."

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 44.52%

  Multiply these two = $2,537.46

- 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 Carrollton, TX of 0.9862= $1,930.84.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,888.70.
  The service portion is found by taking the geographically adjusted rate of $3,888.70 minus the device portion of $2,537.46 = $1,351.24.

  Multiply the service portion by DWC payment adjustment of 235% = $3,175.41.

- Step 3 the MAR is determined by adding the sum of the reimbursement for the device portion of $2,537.46 + the service portion of $3,175.41 = $5,712.87. The insurance carrier paid $5,649.04. As a result, additional reimbursement of $63.83 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $63.83.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $63.83, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		09/20/2019
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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.