



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 MANSFIELD

Respondent Name

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-19-5194-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

AUGUST 13, 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: \$1,054.07

RESPONDENT'S POSITION SUMMARY

"The charge was reimbursed in accordance to the Texas Medical Fee Guidelines for Ambulatory Surgery Center."

Response Submitted by: Avidel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 15, 2019, Ambulatory Surgical Care Services CPT Code 25609-RT, \$1,054.07, \$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.
- 350-Bill has been identified as a request for reconsideration or appeal.

- 756-Per rule 133.250 provider may not submit reconsideration after the carrier has taken final action. Seek MDR in accordance to rule 133.307.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 18-Exact duplicate claim/service.
- W3-Additional payment made on appeal/reconsideration.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on May 15, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of \$1,054.07 for ASC services rendered to the injured worker on May 15, 2019. The insurance carrier paid \$5,675.91 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 44.52%

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 Mansfield, 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 \$2,537.46 = \$1,320.11.

Multiply the service portion by DWC payment adjustment of 235% = \$3,102.25.

- Step 3 the MAR is determined by adding the sum of the reimbursement for the device portion of \$2537.46 + the service portion of \$3,102.25 = \$5,639.71. The insurance carrier paid \$5,675.91. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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 services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

08/30/2019
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.