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
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-20-0017-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 3, 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."

Amount in Dispute: $3,450.88

RESPONDENT'S POSITION SUMMARY

"The review determined that the provider is not dure ['sic'] additional money."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2018	Ambulatory Surgical Care Services CPT Code 25607-LT	$1,233.22	$87.73
	Ambulatory Surgical Care Services CPT Code C1713	$2,217.66	$0.00
TOTAL		$3,450.88	$87.73

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 state fee schedule adjustment
   - 881-This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
   - 889-Device intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
   - 97-The benefit of this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - CIQ378-This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on August 30, 2018?

Findings

1. Texas Surgical Center (requestor) is seeking medical fee dispute resolution in the amount of $3,450.88 for ASC services, CPT codes 25607-LT and C1713, rendered to the injured employee on August 30, 2018. New Hampshire Insurance Co. (respondent) paid $5256.94 for code 25607-LT and $0.00 for C1713 based upon the fee guideline.
2. The fee guidelines for disputed services is found in 28 TAC §134.402.
3. 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.

4. 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.

5. 28 TAC §134.402(b) defines "'ASC device portion' means the portion of the ASC payment rate that represents the cost of the implantable device, and is calculated by applying the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate."
6. The disputed services are described as:

   CPT code 25607 as " Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation."

   HCPCS code C1713 as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

7. To determine if the denial of payment for HCPCS code C1713 is supported the division refers to 28 TAC §133.10(f)(1)(W) that 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." A review of the requestor's CMS-1500 finds the requestor did not

request separate reimbursement for code C1713 per 28 TAC §133.10(f)(1)(W); therefore, the respondent's denial of payment is supported.

8. To determine the appropriate reimbursement for CPT code 25607 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 25607 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 25607 for CY 2018 = $5,606.42.

     This number multiplied by the device dependent APC offset percentage for National Hospital OPPS* reimbursement for code 25607 for CY 2018 is 42.74%.

     Multiply these two = $2,396.18.

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 25607 for CY 2018 is $3,820.11.
     This number is divided by 2 = $1,910.05.
     This number multiplied by the City Wage Index for Midland, TX of 0.9114 = $1,740.81.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,650.86.
     The service portion is found by taking the geographically adjusted rate minus the device portion = $1,254.68.

     Multiply the service portion by DWC payment adjustment of 235% = $2,948.49.

   - Step 3 the MAR is the sum of the device portion + the service portion = $5,344.67. The insurance carrier paid $5,256.94. As a result, additional reimbursement of $87.73 is recommended.

*The offset percentage for 2018 is found on the CMS Hospital Outpatient PPS page. Click on Annual Policy Files on the left hand side of the page, then go to 2018. Click on *2018 OPPS HCPCS Device Offset File* to access to the Final CY 2018 Device offsets.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $87.73.

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 $87.73 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		09/26/2019
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.