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
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-21-2204-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JULY 29, 2021

REQUESTOR'S POSITION SUMMARY

"At this time we are requesting that this claim paid in accordance with the 2021 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $10,346.40

RESPONDENT'S POSITION SUMMARY

"The provider didn't bill with SG modifier to indicate services where for ASC thus prior reviews allowed at physician…Additional recommended $5,472.48."

Response Submitted By: TASB Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2021	Ambulatory Surgical Care Services (ASC) CPT Code 25607	$7,654.99	$0.00
	ASC Services for CPT Code 25652	$3520.47	$0.00
	ASC Services for HCPCS Code C1713	$0.00	$0.00
TOTAL		$10,346.40	$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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective February 22, 2021, sets out the procedures for

resolving medical fee disputes.

2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 350-Bill has been identified as a request for reconsideration or appeal.
   - 59-Processed based on multiple or concurrent procedure rules.
   - 615-Payment for this service has been reduced according to the Medicare multiple surgery guidelines.
   - 618-The value of this procedure is packaged into the payment of other services performed on the same date of service.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-In accordance with rule 34.804, this bill has been identified as a request for reconsideration or appeal.
   - 95-Plan procedures not followed.

Issues

Is the requestor due additional reimbursement for ASC services rendered on March 10, 2021?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $10,346.40 for ASC services rendered on March 10, 2021.
2. The respondent initially paid $3,300.97 for the disputed services based upon the physician fee schedule. The respondent wrote that upon reconsideration an additional allowance of $5,472.48 would be made.
3. To determine the appropriate reimbursement for CPT code 25607 the DWC refers to 28 TAC §134.402(f).

   A. Per ADDENDUM AA, CPT codes 25607 is a device intensive procedure. The requestor did not seek separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(2)(A)(i)(ii) applies.

   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."

   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 2021 = $6,264.95

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25607 for CY 2021 is 43.78%

     Multiply these two = $2,742.80.

   - Step 2 calculating the service portion of the procedure:

Per Addendum AA, the Medicare ASC reimbursement rate for code 25607 for CY 2021 is $4,212.92.
This number is divided by 2 = $2,106.46.
This number multiplied by the City Wage Index for Midland, Texas of 0.8975 = $1890.55.
The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,997.00.
The service portion is found by taking the geographically adjusted rate minus the device portion = $1,254.21.

Multiply the service portion by the DWC payment adjustment of 235% = $2,947.39.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,690.19. This code is subject to multiple procedure discounting of 50% = $2,845.10

The DWC finds the MAR for CPT code 25607 is $2,845.10.

B. Per ADDENDUM AA, CPT codes 25652 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 25652 for CY 2021 = $6,264.95

  The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25652 for CY 2021 is 30.51%

  Multiply these two = $1,911.44.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 25652 for CY 2021 is $3,816.35.
  This number is divided by 2 = $1,908.17.
  This number multiplied by the City Wage Index for Midland, Texas of 0.8975 = $1,712.59.
  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,620.76.
  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,709.32.

  Multiply the service portion by the DWC payment adjustment of 235% = $4,016.90.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $5,928.34.

The DWC finds the MAR for CPT code 25652 is $5,928.34

The DWC finds the MAR for the ASC services rendered on March 10, 2021 is $8,773.44. The respondent initially paid $3,300.97. Upon reconsideration the respondent agreed to issue an additional payment of $5,472.48, for a total payment of $8,773.45. The DWC finds the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the DWC 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 disputed services.

Authorized Signature

		09/01/2021
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 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 with the DWC. **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.