TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Baylor Surgicare at North Dallas

Respondent Name
Texas Mutual

MFDR Tracking Number
M4-22-0677-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
December 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 12, 2021	25607	$2688.20	$0,00
May 12, 2021	C1713	$1636.80	$0.00
	Total	$4312.92	$0.00

Requestor's Position

According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed t the providers cost plus 10% up to $1,000 per item of $2,000.00 per case."

Amount in Dispute: $4312.92

Respondent's Position

Audit is consistent with Rule 134.402 – Ambulatory Surgical Center Fee Guideline. No additional payment.

Response submitted by: Texas Mutual

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC 134.402 sets out the fee guidelines for ambulatory surgical centers.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 763 – Payment made per device intensive methodology
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- D25 – Approved non network provider for Workwell. TX network claimant per Rule 1305.153 (C)
- 763 – Paid per ASC FG at 235%; Implants not applicable or separate reimbursement (w/signed cert) not request. Rule 134.402(G)
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Did the requestor support the implants utilized?

2. What rule applies for determining reimbursement for the disputed services?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking additional reimbursement of implants. A review of the submitted documentation finds the requestor submitted an invoice but did not submit a copy of the implant record to support which implants were billed with code C1713; therefore, additional reimbursement is not recommended
2. The requestor is seeking additional reimbursement of Code 25607 a device intensive code. DWC Rule 28 TAC §134.402 (f) (2) (B) (i) (ii) states,

   (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:

   (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

(ii) the ASC service portion multiplied by 235 percent.

For disputed code 25607 the calculation of the service portion is as follows.

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:

- 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 Dallas, Texas of 0.9744 = $2,052.53
- The sum of these two is the geographically adjusted Medicare ASC reimbursement = $4,158.99
- The service portion is found by taking the geographically adjusted rate minus the device portion = $1,416.19
- Multiply the service portion by the DWC payment adjustment of 235% = -$3,328.04

3. The MAR (maximum allowable reimbursement) for Code 25607 is $3,328.04. The insurance carrier paid $3,675.05. No additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		January 14, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.