TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Physician's Surgical Center

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-22-1858-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 9, 2021	25607	$384.26	$0.00
December 9, 2021	C1713	$2544.30	$0.00
	Total	$2928.56	$0.00

Requestor's Position

"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: $2928.56

Respondent's Position

"Provider incorrectly assets on the Medical Fee Dispute Resolution Request and Appeal Notice that a total of $4,610 is in dispute and is expected as reimbursement for this line. Provider correctly states that they are entitled to "the provider's cost + 10%" but erroneously misinterprets the statue and is claiming the amount due is actually the charge of $4,610.00 + 10%, not the cost of $2,297.00 +10%. ForeSight's review was in accordance with the Texas Statutes, the Operative Report, Implant Log and the Manufacturer Invoices provided…"

Supplemental Response, May 16, 2022: "As explained in the May 6, 2022 letter, the reimbursement is based upon the cost of $2,297 plus 10% rather than the charge of $4,610 plus 10%. The Provider was already reimbursed under CPT codes C1713 in the amount of $2,525.70. This is based upon the cost of $2,297 plus 10%. The Provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 197 – Payment denied/reduced for absence of precertification/authorization
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudication
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines
- 963 – Charge for this procedure exceeds Medicare ASC schedule allowance

Issues

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

Findings

1. The requestor is seeking additional reimbursement of surgery rendered in an ambulatory surgical center and the implant utilized during surgery for date of service December 9, 2021.

DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part 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.

Review of the submitted medical bill found the requestor seeks separate reimbursement of the implants.

DWC Rule 28 TAC §134.402 (f)(2)(B)(i)(ii) states in pertinent part, 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 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 the ASC service portion multiplied by 235 percent.

The following formula was used to calculate the MAR:

Procedure Code 25607 a payment indicator of J8. This is a device intensive procedure paid at an adjusted rate. 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) for code 25607 for applicable date of service is $6,264.95.
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25607 for applicable date of service is 43.75%.
- Multiply these two = $6,264.95 x 43.75% = $2,740.91

Step 2 calculating the **service portion** of the procedure:

- Per Addendum AA, the Medicare ASC reimbursement rate for Code 25607 for applicable date of service is $4,212.92.
- This number is divided by 2 = $4,212.92/2 = $2,106.46
- This number multiplied by the CBSA for Fort Worth, Texas of 0.9697 = $2,106.46 x 0.9697 = $2,042.63
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$2,106.46 + $2,042.63 = $4,149.23.
- The service portion is found by taking the geographically adjusted rate minus the device portion = $4,149.23 - $2,740.91 = $1,408.32
- Multiply the service portion by the DWC payment adjustment of 235% = $1,408.32 x 235% = $3,309.55.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the service portion plus 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.

Review of the submitted documentation did not find a manufacturers invoice to support the amount billed by the requestor. 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

		June 7, 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.