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

General Information

Requestor Name
Memorial Hermann Surgery Center

Respondent Name
Employers Preferred Insurance Co

MFDR Tracking Number
M4-25-0266-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
September 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18, 2024	27792	$5,180.34	$3,900.16
April 18, 2024	C1713	$635.81	$0.00
	Total	$5,816.15	$3,900.16

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration that states, "According to the Workers Compensation 2024 Calculator, we should have been paid $9,057.40 for CPT 27792 and C1713."

Amount in Dispute: $5,816.15

Respondent's Position

The Austin carrier representative for Employers Preferred Insurance Co is Law office of Ricky D Green. The representative was notified of this medical fee dispute on October 8, 2024.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

Response submitted by: N/A

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 Texas Administrative Code (TAC) §134.402 sets out the reimbursement guidelines for ambulatory surgical center fee guidelines.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 TAC §133.10 sets out the medical bill requirements.

Denial Reasons

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

- W3 - Bill is a reconsideration or appeal
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005/5280 – No additional reimbursement allowed after review of appeal/reconsideration.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- 237 – The recommended allowance is based on usual and customary and reasonable rates for this geographical area.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.

Issues

1. Are the implantables separately payable?

2. What rule is applicable to the disputed service?

3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor indicates on the submitted DWC60 an amount in dispute for Code C1713 – anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable). DWC Rule 133.10 (f)(1)(W) states in pertinent parts, "The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care. Supplemental information (shaded portion of CMS-1500/field 24d-24h) is required when the provider is requesting separate reimbursement for surgically implanted devices…" Review of the submitted medical bill found this section was not complete. The request for implants does not meet the requirements of the rule and will not be considered in this review.

2. 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.

   Reimbursement shall be based on the fully implemented payment amount published in the Federal Register. Reimbursement for device intensive procedures shall be the sum of the ASC device portion and the ASC service portion multiplied by 235 percent.

   The following formula was used to calculate the MAR:

   Procedure Code 27792 has 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) code 27792 for applicable date of service = $6,816.33

- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 27792 for applicable date of service is 33.46%

- Multiply these two = $2,280.74

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

- Per Addendum AA, the Medicare ASC reimbursement rate for code 27792 for April 2024 is $4,343.47.

- This number is divided by 2 = $2,171.73

- This number multiplied by the CBSA for The Woodlands, Texas of 1.0026 = $2,177.38.

- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$4,349.11.

- The service portion is found by taking the geographically adjusted rate minus the device portion = $2,068.37.

- Multiply the service portion by the DWC payment adjustment of 235% = $4,860.67.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $7,141.41.

3. The DWC finds the MAR for CPT code 29722 is $7,141.41. The respondent paid $3,241.25. The remaining balance of $3,900.16 is due to the requestor.

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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Employers Preferred Insurance Co must remit to Memorial Hermann Surgery Center $3,900.16 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 23, 2025
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.