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
Complete Surgery
Mesquite

Respondent Name
Pennsylvania Manufacturers Association

MFDR Tracking Number
M4-25-0999-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2024	25390	$3,547.45	$0.00
	Total	$3,547.45	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a copy of a reconsideration dated July 11, 2024 that states, "PMA sent an Explanation of Benefits ("EOB") that indicates the Texas Medical Fee Guideline was utilized however the amount allowed and paid is less than the fee schedule. It appears Travelers calculated the allowed rate at 153% of Medicare instead of 235% of Medicare as the claim was billed."

Amount in Dispute: $3,647.45

Respondent's Position

"We are attaching a copy of the carrier's EOB dated January 9, 2025. We also attaching a copy of the carrier's PLN 11 dated April 19, 2023. The PLN 11 was filed to dispute the extent of the compensable injury. The provider has been paid all the monies that the provider is entitled to."

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.042 sets out the billing requirements and fee guidelines of ambulatory surgical centers.

Denial Reasons

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

- 11 – The recommended allowance for the supply based on the attached invoice.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 128 – The allowance is based on the anesthesia service performed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The recommended allowance is based on a PPO contract held with your facility.
- 983 – Charge for this procedure exceed Medicare ASC guidelines.
- 985 – Service is not allowable under Medicare's ASC guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 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.
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- PRHT – The PPO reduction was taken in accordance to the PHS or leased entity contract. For questions regarding this reduction, please contact Prime Health at 1-86-348-3887 or claimdisputes@primehalthservices.com

Issues

1. Did the respondent raise a new issue?

2. Did the respondent support the PPO reduction?

3. Did the requestor support the cost of implants with required certification statement?

4. What rule is applicable to reimbursement?

5. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the insurance carrier's response finds new denial reasons or defenses raised that were not presented to the requestor before the filing of the request for medical fee dispute resolution specifically extent of compensability.

   A review of the submitted information finds insufficient documentation to support that an EOB was presented to the health care provider, giving notice of the extent of injury denial reasons or defenses raised in the insurance carrier's response to MFDR.

   Rule §133.307(d)(2)(F) requires that: The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

2. The explanation of benefits included with this dispute references a PPO contract. Review of the submitted documentation and information known to the division does not support the injured worker is enrolled in a certified health network. The reduction taken by the insurance carrier is not supported and will not be considered in this review.

3. DWC Rule 28 TAC §134.402 (g) (1) (B) states in pertinent parts, "A facility, or surgical implant provider requesting reimbursement for the implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provide may be entitled."

   Review of the submitted documentation found insufficient evidence to support the required billing certification. The rendered services will be reviewed based on reimbursement policy WITHOUT implants.

4. 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.

DWC Rule 134.402 (f)(2)(A)(i)(II) states in pertinent parts, "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 25390 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 25390 for applicable date of service = $6,816.33
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25390 for applicable date of service is 34.60%
- Multiply these two = $2,358.45

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

- Per Addendum AA, the Medicare ASC reimbursement rate for code 25390 for CY 2024 is $4,491.69.
- This number is divided by 2 = $2,245.84.
- This number multiplied by the CBSA for Mesquite, Texas of 0.9625 = $2,161.62.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$4.407.46
- The service portion is found by taking the geographically adjusted rate minus the device portion = $2,049.01

- Multiply the service portion by the DWC payment adjustment of 235% = $4,815.17.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $7,173.62.

5. The DWC finds the MAR for CPT code 25390 is $7,173.62. The respondent paid $9,774.66. 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 entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 12, 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.