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
Legent Outpatient Surgery
Austin

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-25-1350-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
February 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 30, 2024	23485	$370.27	$0.00
	Total	$370.27	$0.00

Requestor's Position

The requestor submitted a copy of their reconsideration that states, "...We have been underpaid per the Texas Worker's Compensation Fee Schedule... ...4. 2024 Device offset for CPT 23485 per addendum FF was 38.14% this makes the device portion fur us to $4558.57. The service portion would be $3730.01."

Amount in Dispute: $370.27

Respondent's Position

"...The Provider cites to Addendum FF of the Medicare reimbursement rules in support of their contention additional reimbursement is due. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated. Addendum P is the proper OPPS addendum for this procedure. The Carrier contends the Provider is not entitled to additional reimbursement."

Response submitted by: Travelers

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 §134.402 sets out the fee guidelines for ambulatory surgical center fee guideline.

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.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- 86 – Service performed was distinct or independent from other services performed on the same day.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- W3 – Bill is a reconsideration or appeal
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule.
- 947 – Upheld, no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the requestor's position statement supported?

2. What rule is applicable to reimbursement?

3. Is requestor entitled to additional reimbursement?

Findings

1. The requestor states in their position statement, … "Device offset for CPT 23485 per addendum FF

was 38.14%... " DWC Rule 134.402 (b) (2) states, ""ASC device portion" means the portion of the ASC payment rate that represents the cost of the implantable device, and is calculated by applying the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate."

The OPPS device offset percentage is found in Addendum P at www.cms.gov, and indicates the amount for code 28485 is 38.54%. This amount will be in the calculation of the MAR shown below.

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 23485 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 23485 for applicable date of service = $12,539.82.
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 23485 for applicable date of service is 38.54%
- Multiply these two = $4,832.85

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

- Per Addendum AA, the Medicare ASC reimbursement rate for code 23485 for CY 2024 is $8,574.54.
- This number is divided by 2 = $4,287.27.
- This number multiplied by the CBSA for Austin, Texas of 0.9333 = $4,001.31.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$8,288.58.
- The service portion is found by taking the geographically adjusted rate minus the device portion = $3,455.73.
- Multiply the service portion by the DWC payment adjustment of 235% = $8,120.96.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $12,953.81.

3. The DWC finds the MAR for CPT code 23485 is $12,953.81. The respondent paid $13,024.91. 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

		March 11, 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.