



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Legent Outpatient Surgery  
Austin

**Respondent Name**

Charter Oak Fire Insurance Co.

**MFDR Tracking Number**

M4-25-1388-01

**Carrier's Austin Representative**

Box Number 5

**DWC Date Received**

February 21, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 18, 2024	25607	\$275.41	\$0.00

### Requestor's Position

"We are expecting \$275.41 in additional payment..."

1. \$4397.34 Travis County Local allowed amount for CPT 25607 (wage index 0.9333 for 2024)
2. We ARE NOT asking for Separate reimbursement for implants...
8. We were only paid \$6628.08. We are expecting an additional 275.41."

**Amount in Dispute:** \$275.41

### Respondent's Position

"The Carrier has reviewed the documentation and contends the Provider has been appropriately reimbursed for the services at issue. 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 §133.305](#) sets out general Medical Dispute Resolution guidelines.
3. [28 TAC §134.402](#) sets out the fee guidelines for ambulatory surgical centers.

### Adjustment Reasons

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

- 4123 - Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 983 - Charge for this procedure exceeds Medicare ASC schedule allowance.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 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.
- 1115 - We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 - No additional reimbursement allowed after review of appeal/reconsideration.

### Issues

1. What Rule applies to the reimbursement of the service in dispute?
2. Is the requestor entitled to additional reimbursement for the disputed service?

## Findings

1. This medical fee dispute involves facility charges for surgical services rendered in a licensed ambulatory surgical center. The requestor, Legent Outpatient Surgery Austin, is requesting additional reimbursement for surgical procedure code 25607.

DWC Rule 28 TAC §134.402 (d), which applies to the disputed service, 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](http://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 maximum allowable reimbursement (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.

2. The requestor is seeking additional reimbursement in the amount of \$275.41 for procedure code 25607 rendered on October 18, 2024, in a licensed ambulatory surgical center. On the disputed date of service, the requestor billed for one unit of procedure code 25607-LT and eight units of C1713. Separate reimbursement for implants was not requested on the medical bill.

In accordance with 28 TAC §134.402, the MAR for the service in dispute is calculated as follows:

Procedure Code 25607 has an ASC payment indicator of J8 which indicates a device intensive procedure paid at an adjusted rate.

The following formula is used to calculate the MAR:

Step 1 calculating the **device portion** of the procedure:

Per 28 TAC §134.402 (b)(2), "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 device offset percentage information can be found in the [CMS OPPS Addendum P](#).

- The national reimbursement is found in Addendum B for National Hospital Outpatient Prospective Payment System (OPPS). The rate for procedure code 25607 on the applicable date of service = \$6,816.33.
- The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 25607 for the applicable date of service is 40.27%.
- Multiply the above  $\$6,816.33 \times 40.27\% = \$2,744.94$ , the device portion of the procedure.

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

Per 28 TAC §134.402 (b)(3), "ASC service portion" means the Medicare ASC payment rate less the device portion.

- Per Addendum AA, the Medicare ASC reimbursement rate for code 25607 for CY 2024 is \$4,549.05.
- This number is divided by 2 = \$2,274.53.
- This number multiplied by the CBSA for Austin, Texas of 0.9333 = \$2,122.82.
- The sum of these two,  $\$2,274.53 + \$2,122.82$ , is the geographically adjusted Medicare (MC) ASC reimbursement = \$4,397.35.
- The service portion is found by subtracting the device portion \$2,744.94 from the geographically adjusted MC ASC rate \$4,397.35 = \$1,652.41
- Multiply the service portion by the DWC payment adjustment of 235% = \$3,883.16, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion \$2,744.94 and the final DWC service portion \$3,883.16 = \$6,628.10.

DWC finds the MAR for the disputed CPT code 25607, rendered on October 18, 2024, is \$6,628.10. The insurance carrier paid \$6,628.08. Therefore, no additional reimbursement 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 requestor 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 additional reimbursement in the amount of \$0.00 for the disputed services.

**Authorized Signature**

		April 16, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).