



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Baylor Scott & White  
Surgicare

**Respondent Name**

Texas Mutual Insurance Co.

**MFDR Tracking Number**

M4-25-1445-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

February 28, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2024	23615	\$16,004.00	\$5,223.98

### Requestor's Position

"We are disputing the payment of the CPR code 23615 as a J8 Device intensive code that should have received 235% of the Service rate and Implants at the invoice costing plus 10%."

**Amount in Dispute:** \$16,004.00

### Respondent's Position

"Review of the audit confirms that CPT code [23615] has a J8 status indicator which means the payment method applied is per Medicare device intensive method per CMS Guidelines. Reimbursement is 235% of service portion for CPT code [23615] (\$3,534.11 service x 2.35 \$8,305.16). Facility was requesting separate reimbursement for implants, however the facility did not submit the signed certification per Rule 134.402 therefore recommended payment was less 10% pending signed certification. The bill was processed in accordance with ASC Rule 134.402, no additional payment is due."

**Response submitted by:** Texas Mutual Insurance Co.

## 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:

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- D25 - NON-NETWORK PROVIDER FOR WORKWELL, TX NETWORK CLAIMANT PER RULE 1305.153 (C).
- J16 - THIS PROCEDURE CODE WAS RANKED AS THE PRIMARY SERVICE WHEN CONSIDERED FOR MULTIPLE PROCEDURE REDUCTION. AS A RESULT, NO REDUCTION WAS TAKEN.

### 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, Baylor Scott & White Surgicare, is requesting additional reimbursement for surgical procedure code 23615.

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 multiplied by 235 percent.

2. The requestor is seeking additional reimbursement in the amount of \$16,004.00 for procedure code 23615 rendered on September 26, 2024, in a licensed ambulatory surgical center. On the disputed date of service, the requester billed for one unit of procedure code 23615-SG-RT in addition to other related surgical procedures and implants. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) request form finds that 23615 is the only procedure code in dispute. Therefore, only procedure code 23615 will be reviewed in this MFDR process.

Separate reimbursement for implants was requested on the medical bill. In accordance with 134.402 (g) "A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable. (1) The facility or surgical implant provider requesting reimbursement for the implantable shall:

- (A) bill for the implantable on the Medicare-specific billing form for ASCs;
- (B) 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 provider may be entitled."

A review of the documents submitted finds no certification of cost statement for surgical implantables and no reimbursement amount was paid by the insurance carrier for implantables. Therefore, the request for separate reimbursement of implantables will be disregarded in calculating the MAR for this review.

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

Procedure Code 23615 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 23615 on the applicable date of service = \$12,539.82.
- The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 23615 on the applicable date of service is 41.28%.
- Multiply the above  $\$12,539.82 \times 41.28\% = \$5,176.44$ , 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 23615 for CY 2024 is \$8,868.24.
- This number is divided by 2 = \$4,434.12.
- This number multiplied by the CBSA for Ft. Worth, TX region, of 0.969 = \$4,296.66.
- The sum of these two,  $\$4,434.12 + \$4,296.66$ , is the geographically adjusted Medicare (MC) ASC reimbursement = \$8,730.78.
- The service portion is found by subtracting the device portion \$5,176.44 from the geographically adjusted MC ASC rate \$8,730.78 = \$3,554.34.
- Multiply the service portion by the DWC payment adjustment of 235% = \$8,352.70, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion \$5,176.44 and the final DWC service portion \$8,352.70 = \$13,529.14.

DWC finds the MAR for the disputed CPT code 23615, rendered on September 26, 2024, is \$13,529.14. A review of the explanation of benefits submitted finds that the insurance carrier paid \$8,305.16 for procedure code 23615 on the disputed date of service. Therefore, additional reimbursement in the amount of \$5,223.98 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 established that additional reimbursement in the amount of \$5,223.98 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 Texas Mutual Insurance must remit to Baylor Scott & White Surgicare \$5,223.98 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

_____	_____	April 17, 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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).