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

General Information

Requester Name
Complete Surgery
Mesquite

Respondent Name
WC Solutions

MFDR Tracking Number
M4-25-1489-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 4, 2024	25608	$514.19	$514.19
September 4, 2024	25606	$1,490.44	$0.00
September 4, 2024	64450	$45.63	$0.00
	Total	$5480.00[sic] $2,050.26	$514.19

Requester's Position

"The requester did not submit a position statement with the request for MFDR. They did submit a copy of their reconsideration dated October 31, 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."

Supplemental response July 17, 2025

"We would like to continue dispute resolution."

Amount in Dispute: $5,480.00 [sic] $2,050.26

Respondent's Position

"Our records show a total of $6,020.98 has been paid for the charges in dispute. …We hope this resolves the dispute at hand."

Response submitted by: Ethos

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 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 reimbursement.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 899 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Musculoskeletal system procedure (200000-29999) has been disallowed.
- 903 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Endocrine, nervous, eye and ocular adnexa, auditory systems procedure (60000-699999) has been disallowed.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- 985 – Service is not allowable under Medicare's ASC guidelines.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 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 – Reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1241 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
- 5044 – Additional payment made on appeal/reconsideration.
- 6000 – Request for reconsideration.

Issues

1. What charges are in dispute?

2. Did the requester submit required elements when requesting separate implant reimbursement?

3. Is the insurance carrier's denial based on CCI edits supported?

4. What rule is applicable to reimbursement?

5. Is Requester entitled to additional reimbursement?

Findings

1. The requester submitted a DWC060 form on March 7, 2025 that indicates a total amount in dispute of $5,480.00. However, the amounts listed under column titled, "Amount in Dispute" totals $2,050.26. This total will be considered the amount in dispute.

2. The submitted medical bill contained the following statement, "CSM request separate reimbursement for implants." DWC Rule 28 TAC §134.402 (2)(B)(i) states, "If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:

   (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission;

   The document submitted is Zimmer Blomet PO Request with the statement, "THIS IS NOT AN INVOICE." DWC finds the requester did not submit the required invoice that would allow for reimbursement per DWC guideline.

   DWC Rule 28 TAC §134.402(g) states, 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.

Review of the submitted documentation found insufficient evidence that the requester included the required certification as to the cost of the implants. DWC finds the requester did not meet the requirements of separate implant reimbursement.

3. The submitted DWC060 indicates the following line items are in dispute.
    - 25608 – Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments.
    - 25606 – Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation.
    - 64450 – Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch.

    The insurance carrier denied code 25606 and 64450 based on Clinical Based Coding Edits.

    DWC Rule 28 TAC §134.402 (d) states, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided

    DWC Rule 28 TAC §134.402 (6) states, "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

    Review of the applicable National Correct Coding Initiative Edits at www.cms.gov, found an edit exists between Code 25606 and 25608 and an edit exists between code 64450 and 25608. The insurance carrier's denial is supported no reimbursement is recommended.

4. The remaining code in dispute is 25608 – Open treatment of distal radial intra-articular fracture or epiphyseal separation. 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 25608 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 xxx for applicable date of service = $6,816.33
- The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 25608 for applicable date of service is 41.23%
- Multiply these two = $6816.33 x 41.23% = $2,810.37

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

- Per Addendum AA, the Medicare ASC reimbursement rate for code 25608 for applicable date of service is $4,597.60.
- This number is divided by 2 = $2,298.80.
- This number multiplied by the CBSA for Mesquite, Texas of 0.9625= $2,212.60.
- The sum of these two is the geographically adjusted Medicare ASC reimbursement =$2,212.60 + $2,298.80 = $4,511.40
- The service portion is found by taking the geographically adjusted rate minus the device portion = $1,701.03
- Multiply the service portion by the DWC payment adjustment of 235% = $3,997.42.

Step 3 calculating the MAR:

- The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $2,810.37 + $3,997.42 = $6,807.79.

5. The DWC finds the MAR for CPT 25608 is $6,807.79. The respondent supported payments in the amounts of.

- Control number 2223721 for $3,997.42

- Control number 2230345 for $956.34
- Control number 2241389 for $1,067.22
- Total payment of $6,020.98

The balance remaining is $786.81. The DWC060 indicates the requested amount for code 25608 is $514.19. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to reimbursement for the disputed services. It is ordered that WC Solutions must remit to Complete Surgery Mesquite $514.19 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 31, 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.