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
Baylor Scott & White Surgicare

Respondent Name
National Union Fire Ins Co of Pitts PA

MFDR Tracking Number
M4-25-2128-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 5, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 17, 2024	27654	$1,333.80	$0.00
September 17, 2024	C9290	$377.72	$0.00
	Total	$1,711.52	$0.00

Requestor's Position

"... our estimated expectation of payment allowable based on a Device Intensive case code has denied with no further payment and no explanation as to why. They refer to the original payment was correct. We feel they have not calculated the surgery code billed correct to our ASC billing as well as they have denied the C9290 based on "not on fee schedule" which is not correct."

Amount in Dispute: $1,711.52

Respondent's Position

"With respect to code C9290, the provider billed $912.65. The provider is seeking payment of $377.72. We are attaching a copy of the Carrier's EORs dated October 25, 2024, and January 3, 2025. The Carrier continues to maintain its position for code 27654. However, it is paying the additional amount to the provider for code C9290. No additional monies are owed."

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 §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Denial Reasons

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

For Procedure code 27654

- 4123 - Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 983 - Charge for this procedure exceeds Medicare ASC schedule allowance.
- 2008 - Additional payment made on appeal/reconsideration.
- 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.
- W3 - Bill is a reconsideration or appeal.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.

For Procedure code C9290

- 242 - According to the fee schedule, this charge is not covered.
- 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.
- 2005 - No additional reimbursement allowed after review of appeal/reconsideration.
- 96 - Non-covered charge.
- 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.

Issues

1. What Rule applies to the reimbursement of the service in dispute?
2. Does the submitted medical record support that the services in dispute were rendered on the disputed date of service?
3. 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 27654 and C9290.

   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, 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 procedure codes in dispute for date of service September 17, 2024, are described as follows:
   - Procedure code 27654 - Repair, secondary, Achilles tendon, with or without graft.
   - Procedure code C9290 - Injection, bupivacaine liposome, 1 mg. When billing for HCPCS code C9290, healthcare providers need to document the administration of the bupivacaine liposome injection in the patient's medical record. This documentation should include details such as the date of the procedure, the dosage administered, the

injection site, and any relevant patient information.

A review of the submitted medical record supports that the Achilles tendon repair, billed under procedure code 27654 as defined above, was rendered to the injured employee on the disputed date of service, September 17, 2024.

DWC's review of the submitted medical record does not support that an injection of bupivacaine liposome, billed under procedure code C9290 as defined above, was rendered to the injured employee on the disputed date of service, September 17, 2024. Therefore, procedure code C9290 will not be further reviewed or considered for reimbursement.

3. The requestor is seeking additional reimbursement in the amount of $1,333.80 for procedure code 27654 rendered on September 17, 2024, in a licensed ambulatory surgical center. On the disputed date of service, the requestor billed for one unit of procedure code 27654-SG-RT. On the same date of service and same medical bill, the requester charged 266 units of procedure code C9290, which, as noted in finding number two, is not considered for reimbursement. 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 27654 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 27654 on the applicable date of service = $6,816.33.
   - The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 27654 on the applicable date of service is 33.62%.
   - Multiply the above $6,816.33 x 33.62% = $2,291.650, 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 27654 for CY 2024 is $4,272.77.
- This number is divided into 2 = $2,136.385.
- This number multiplied by the CBSA for Fort Worth, Texas region of 0.969 = $2,070.157.
- The sum of these two, $2,136.385 + $2,070.157, is the geographically adjusted Medicare (MC) ASC reimbursement =$4,206.542
- The service portion is found by subtracting the device portion $2,291.650 from the geographically adjusted MC ASC rate $4,206.542 = $1,914.892
- Multiply the service portion, $1,914.892 by the DWC payment adjustment of 235% = $4,499.996, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion $2,291.65 and the final DWC service portion $4,499.996 = $6,791.65.

DWC finds the MAR for the disputed CPT code 27654, rendered on September 17, 2024, is $6,791.65. The insurance carrier paid $6,791.64. 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

		June 9, 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.