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

Requester Name
LEGENT INTERVENTIONAL PAIN CENTER

Respondent Name
CITY OF FORT WORTH

MFDR Tracking Number
M4-25-3387-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
August 25, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 8, 2025	63685, 63664, C1820, C1778	$7,886.97	$0.00

Requester's Position

Excerpt from second level appeal dated July 23, 2025: "We are asking you to review your Calculations on your payment. We have been underpaid per the NEW TX WC Fee Schedule - below are the calculations. We are Expecting $7,886.97 in an additional payment per the TX Work Comp Contract."

Amount in Dispute: $7,886.97

Respondent's Position

"The City stands by its denial that no additional payment is owed and attaches the EOBs reflecting same. The City respectfully requests this Division to dismiss this request for MFDR."

Response submitted by: RICKY D. GREEN, PLLC

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.
- 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.
- N702 - Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.
- 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.
- 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 services in dispute?
2. According to DWC applicable Rules, what is the total maximum allowable reimbursement (MAR) for the services rendered on the date in dispute?

3. Is the requester entitled to additional reimbursement for the services in dispute?

Findings

1. This medical fee dispute involves facility charges for surgical services rendered on April 8, 2025, in a licensed ambulatory surgical center (ASC).

   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. On the disputed date of service, the requester billed one unit each of the following procedure codes: CPT codes 63685, 63664, C1820, and C1778. Separate reimbursement for implants was not requested on the medical bill.

   The procedure codes billed on the disputed date of service are described as:

   - CPT code 63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver.
   - CPT code 63664 - Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed.
   - CPT code C1820 - Generator, neurostimulator (implantable)*, with rechargeable battery and charging system.
   - CPT code C1778 - Lead, neurostimulator (implantable)*.

*Separate reimbursement for implants was not requested on the medical bill; therefore, the implant codes will not be calculated for MAR in this medical fee dispute resolution (MFDR) review.

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

Procedure Code 63685 has an ASC payment indicator of J8 which indicates a device intensive procedure paid at an adjusted rate. Per ASC Addendum AA, this procedure code is not subject to the multiple procedure payment reduction (MPPR) rule.

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 payment rate for procedure code 63685 on the applicable date of service = $30,473.59.
- The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 63685 on the applicable date of service is 80.75%.
- Multiply the above $30,473.59 x 80.75% = $24,607.424, 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 63685 for CY 2025 is $26,281.67.
- This number is divided into 2 = $13,140.835.
- This number multiplied by the CBSA for Tarrant County/Fort Worth, Texas region of 0.9558 = $12,560.010.
- The sum of these two, $13,140.835 + $12,560.010, is the geographically adjusted Medicare (MC) ASC reimbursement =$25,700.845
- The service portion is found by subtracting the device portion $24,607.424

from the geographically adjusted MC ASC rate $25,700.845 = $1,093.421.

- Multiply the service portion, $1,093.421 by the DWC payment adjustment of 235% = $2,569.539, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion $24,607.424 and the final DWC service portion $2,569.539 = $27,176.96.

DWC finds the MAR for the disputed CPT code 63685, rendered on April 8, 2025, is $27,176.96.

Procedure Code 63664 has an ASC payment indicator of J8 which indicates a device intensive procedure paid at an adjusted rate. Per ASC Addendum AA, this procedure code is not subject to the multiple procedure payment reduction (MPPR) rule.

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 payment rate for procedure code 63664 on the applicable date of service = $12,470.31.

- The device dependent APC offset percentage for National Hospital OPPS in Addendum P for code 63685 on the applicable date of service is 49.71%.

- Multiply the above $12,470.31 x 49.71% = $6,198.991, 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 63664 for CY 2025 is $9,132.06.

- This number is divided into 2 = $4,566.03.

- This number multiplied by the CBSA for Tarrant County/Fort Worth, Texas

region of 0.9558 = $4,364.211.

- The sum of these two, $4,566.03 + $4,364.211, is the geographically adjusted Medicare (MC) ASC reimbursement =$8,930.241
- The service portion is found by subtracting the device portion $6,198.991 from the geographically adjusted MC ASC rate $8,930.241 = $2,731.25.
- Multiply the service portion, $2,731.25 by the DWC payment adjustment of 235% = $6,418.439, the final DWC service portion amount.

Step 3 calculating the **MAR**:

- The MAR is determined by adding the sum of the device portion $6,198.991 and the final DWC service portion $6,418.439 = $12,617.43.

DWC finds the MAR for the disputed CPT code 63664, rendered on April 8, 2025, is $12,617.43.

According to DWC applicable Rules and calculations shown above for the disputed services rendered on April 8, 2025, in a licensed ASC, the total MAR is $39,794.39.

3. The requester is seeking additional reimbursement in the total amount of $7,886.97 for services rendered on April 8, 2025, in a licensed ambulatory surgical center.

   As indicated in the previous finding, the total MAR for the services in dispute is $39,794.39.

   A review of the submitted explanation of benefits (EOB) dated May 14, 2025, finds that the insurance carrier has previously reimbursed the disputed services rendered on April 8, 2025, in the total amount of $39,794.41.

   DWC finds that the requester is not entitled to additional reimbursement for the services in dispute rendered on April 8, 2025, in a licensed ambulatory surgical center.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to additional reimbursement in the amount of $0.00 for the disputed services.

Authorized Signature

		September 25, 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.