TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CALLOWAY CREEK SURGERY CENTER

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-21-1065-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
MARCH 1, 2021

REQUESTOR'S POSITION SUMMARY

"Total Correct Work Comp Allowable $9,839.31."

Amount in Dispute: $1,835.37

RESPONDENT'S POSITION SUMMARY

"ForeSight is claiming nothing further is due and owing for the implant charges."

Response Submitted by: Foresight

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2020	Ambulatory Surgical Care Services (ASC) CPT Code 27427	$1,342.97	$0.00
	ASC Services for HCPCS Code C1762	$193.07	$0.00
	ASC Services for HCPCS Code C1713	$299.33	$0.00
TOTAL		$1,835.37	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. 28 TAC §134.600, effective March 30, 2014, requires preauthorization for specific treatments and services.
4. 28 TAC §133.10, effective April 1, 2014, sets out the healthcare provider billing procedures.
5. The insurance carrier reduced/denied payment for the disputed services with the following claim adjustment codes:
   - 45-Charge exceeds fee schedule maximum allowable or contracted/legislated fee arrangement.
   - 8999-PPO reduction is in accordance with the Sedgwick Preferred Network contract.
   - 6981-Charges for surgical implants are reviewed separately by ForeSight.
   - P13-Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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.

Issues

Is the requestor entitled to additional reimbursement for ASC services rendered on March 19, 2020?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $1,835.37 for ASC services rendered on March 19, 2020.
2. The respondent contends that reimbursement of $7,967.32 was made per Sedgwick Preferred Network contract.

   28 TAC §133.307(d)(2)states,

   > Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records:
   > (D) any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor;
   > (E) a statement of the disputed fee issue(s), which includes: (iv) a discussion regarding how the submitted documentation supports the respondent's position for each disputed fee issues.

   A review of the submitted documentation does not support a network contractual agreement exists between the parties; therefore, the disputed services will be reviewed per the fee guideline.
3. The fee guidelines for disputed services is found in 28 TAC §134.402.

   28 TAC §134.402(b) (6) states,

   > Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. "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.

   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 with any additions or exceptions specified in this section, including the following paragraphs.

The disputed services are described as:

- 27427-Ligamentous reconstruction (augmentation), knee; extra-articular.
- C1762-Connective tissue, human (includes fascia lata).
- C1713-Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable).

4. To determine the appropriate reimbursement for CPT code 27427 the DWC refers to 28 TAC §134.402(f). The requestor sought separate reimbursement for the implantables.

   Per ADDENDUM AA, CPT codes 27427 is a device intensive procedure. The requestor sought separate reimbursement for the implantables; therefore, 28 TAC §134.402(f)(2)(B)(i)(ii) applies.

   28 TAC §134.402(f)(2)(B)(i)(ii) states,

   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 as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: B) 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; and

   (ii) the ASC service portion multiplied by 235 percent.

   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 27427 for CY 2020 = $5,981.95

     The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 27427 for CY 2020 is 34.29%

     Multiply these two = $2,051.21

   - Step 2 calculating the service portion of the procedure:

     Per Addendum AA, the Medicare ASC reimbursement rate for code 27427 for CY 2020 is $3,630.88.
     This number is divided by 2 = $1,815.44.
     This number multiplied by the City Wage Index for North Richland Hills, Texas of 0.9792 = $1,777.68.
     The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,593.12.
     The service portion is found by taking the geographically adjusted rate minus the device portion = $1,541.91.

     Multiply the service portion by the DWC payment adjustment of 235% = $3,623.49.

   The DWC finds the MAR for CPT code 27427 is $3,623.49.

5. The requestor billed for the implantables with HCPCS codes C1713 and C1762.

   28 TAC §134.402(b)(5) states "Implantable" means an object or device that is surgically:
   (A) implanted,
   (B) embedded,

(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program, and recharge the implantable."

Per 28 TAC §134.402(f)(2)(B)(i) the following formula was used to calculate the MAR:

Implant (Per Implant Record)	No. Of Units	Cost	Cost + 10%
Anterior Tibialis Tendon	1	$1,516.50	$1,668.15
ACL Tight Rope with Fiber Tag	2	$750.00 X 2 = $1,500.00	$1,650.00
Dis Instr Kit for Teno Scrw	1	$279.00	$306.90
BioComp Swivellock C	1	$572.00	$629.20
TOTAL			$4,254.25

The DWC finds the MAR for the ASC services rendered on March 19, 2020 is $7,877.74 (3,623.49 + $4,254.25). The respondent paid $7,967.32. The DWC finds the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/26/2021 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.