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
Grapevine Surgicare

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-2217-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 2, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 1,2020	Ambulatory Surgical Care Services, (ASC), CPT Code 27698	$0.00	$0.00
	ASC HCPCS Code C1713	$2,184.49	$357.50
	Total	$2,184.49	$357.50

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2020 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $2,184.49

Respondent's Position

"ForeSight reviewed Revenue Code 0278 HCPCS C1713 on behalf of TriStar for Indemnity Insurance Company of North America. Please find enclosed the ForeSight Position Statement and supporting documentation."

"ForeSight is agreeing with the provider that an additional allowance is due for the implants up to a total allowance of $2,899.60."

Response Submitted By: ForeSight

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 ASC services.

Denial Reasons

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

- W3-Additional payment made on appeal/reconsideration.
- 6981-Charges for surgical implants are reviewed separately by ForeSight Medical.
- P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
- 247-A payment or denial has already been recommended for this service.
- 18-Exact duplicate claim/service.

1. Is Grapevine Surgicare entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,184.49 for ASC services rendered on September 1, 2020.

   The respondent paid $7,144.14 ($4,244.54 + $2,899.60) for the disputed services based upon the fee guideline.

   A. Per Addendum AA, CPT code 27698 is a non-device intensive procedure. The requestor sought separate reimbursement for implantables.

   28 TAC §134.402(f)(1)(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: (1) Reimbursement for non-device intensive procedures shall be: (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-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 Medicare ASC facility reimbursement amount multiplied by 153 percent.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 27698 CY 2021 is $2,929.17.

The Medicare ASC reimbursement is divided by 2 = $1,464.59.

This number multiplied by the City Wage Index for Grapevine, Texas of 0.9792= $1,434.12.

Add these two together = $2,898.71.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $4,435.03. The requestor is not seeking additional reimbursement for this code.

B. The requestor is seeking additional reimbursement of $2,184.49 for implantables, HCPCS code C1713.

The DWC reviewed the submitted documentation and finds:

Implant #	No. of Units	Invoice	Cost + 10%	Insurance Carrier Paid	Amount Due
AR-1322BCNF	2	$325.00 X 2= $650.00	$715.00	$2,899.60	$357.50
AR-1322DSC	1	$175.00	$192.50		
AR-1787PJ-CP	1	$2,136.00	$2,349.60		
Total		$2,961.00	$3,257.10	$2,899.60	$357.50

The DWC finds the MAR for the ASC services rendered on September 1,2020 is $7,692.13. The respondent paid $7,144.14. The difference for both codes is $547.99. The requestor is due additional reimbursement of $357.50 for HCPCS code C1713.

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 $357.50 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 Indemnity Insurance Co. of North America must remit to Grapevine Surgicare $357.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.}

Authorized Signature

		10/26/2021
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, option 3 or email CompConnection@tdi.texas.gov.