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
Physicians Surgical Center

Respondent Name
City of Fort Worth

MFDR Tracking Number
M4-22-0605-01

Carrier's Austin Representative
Box Number 4

DWC Date Received
November 29, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 11, 2021	23410	$0.00	$0.00
March 11, 2021	29822	$0.00	$0.00
March 11, 2021	64415	$0.00	$0.00
March 11, 2021	76942	$0.00	$0.00
March 11, 2021	C1713	$3370.16	$0.00
March 11, 2021	C9290	$378.18	$0.00
	Total	$3746.32	$0.00

Requestor's Position

According to Texas Workers Compensation Rule 134.402, "Implantable devices are reimbursed at the providers cost plus 10% up to $1,000.00 per item or $2,000.00 per case." …We are owed an additional payment of $3746.32

Amount in Dispute: $3746.32

Respondent's Position

…ForeSight s disagreeing with the provider that an additional allowance is due. Provider incorrectly asserts they are due for an amount equal to their "charges + 10%" not the statutory amount of their "cost – 10%". Provider failed to properly disclose their cost for items HCPCS

C1713 by incorrectly asserting their cost was the charged amount of $3,370.16 and not the true cost of $1,2836.24 as supported by their own manufacturer invoices supplied with their documents. As such, ForeSight contends the provider was adequately compensated for the implants up to a total allowance of $1,414.86 as calculated above.

Response Submitted by: Foresight Medical LLC

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 centers.

Denial Reasons

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

- 16 – Claim/service lacks information which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

Issues

1. What amount will be reviewed as MFDR?

2. Is the insurance carriers' reduction supported?

3. What rule applies for determining reimbursement for the disputed services?

Findings

1. The requestor is seeking additional reimbursement of Code C1713 – Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)and C9290 - Injection, bupivacaine liposome, 1 mg.

   The requestor's medical bill indicates a charge for $3063.78 for C1713 and $341.96 for C9290.

   The amount shown in dispute on the DWC060 for C1713 is $3370.16 and $378.13 for C9290.

Insufficient evidence was found to support the additional amount in dispute. The charges that were submitted and billed to the insurance carrier will be reviewed.

2. DWC Rule 28 TAC §134.402 (f) (B) (i) states in pertinent part 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;

   The requestor submitted invoice number 452686-GM5387 in support of the cost of the implants.

   The OR Charge Sheet shows JuggerKnot Soft Anchors (4) with a cost of $239.06 each or $956.24.

   Quattro Link Knotless Anchor (1) with a cost of $330.00

   The total supported cost is $1,286.24.

   Per the above rule the maximum allowable reimbursement for C1713 is $1,414.86 ($1,286.24 + 10% or $128.62). The insurance carrier paid $1,414.86. No additional payment is recommended.

3. The requestor also listed Code C9290 - Injection, bupivacaine liposome, 1 mg on the DWC060 requesting review.

   DWC Rule 134.402 (f) 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.

   Review of the applicable Addendum at www.cms.gov, Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2021 (Including Ancillary Services for Which **Payment is Packaged**) found Code C9290 is considered packaged. No additional reimbursement can be 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 requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

		January 11, 2022
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.