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
General Casualty Co of Wisconsin

MFDR Tracking Number
M4-22-1822-01-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
April 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 8, 2021	29882	$0.00	$0.00
	64447	$0.00	$0.00
	27599	$0.00	$0.00
	76942	$0.00	$0.00
	C1713	$455.30	$0.00
	Total	$455.30	$0.00

Requestor's Position

"At this time we are requesting that this claim paid in accordance with the 2018 Texas Workers Compensation Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $455.30

Respondent's Position

"As noted in Foresight's letter, the Provider is claiming that it is entitled to the charge plus 10% rather than the Provider's cost plus 10%. The charge was $4,553 whereas the cost was $4,175. It is the Carrier's position that the Provider is not entitled to any additional reimbursement."

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 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 the payment for the disputed services with the following claim adjustment codes:

- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical. Please expect a detailed explanation of review for surgical implant charges directly from ForeSight Medical and direct all surgical implant inquiries to ForeSight Medical at 813-930-5346
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
- 10 – Upon review of submitted request for reconsideration, ForeSight has determined no additional allowance will be made

Findings

1. The requestor is seeking additional reimbursement for implants provided during a surgical procedure done in an ambulatory surgical center on September 8, 2021.

   The insurance carrier reduced the allowed amount based on the worker's compensation fee schedule.

   As stated above, per 28 TAC §134.402 (f)(1)(B) and (f)(2)(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."

   Per the Operative Report the following implants were used in the procedure:

Implant Name	Units	Cost
BioComposite Swivelock	1	$400.00

Knee Kit	1	$3,775.00
		$4,175.00 +10% =$4,592.50

The total maximum allowable for the disputed service is $4,592.50. The insurance carrier paid $4,553.00. No additional payment 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 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

Signature	Medical Fee Dispute Resolution Officer	May 27, 2022 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.