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
Grapevine Surgicare

Respondent Name
Hartford Insurance Company of Midwest

MFDR Tracking Number
M4-17-3187-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are owed an additional payment of $416.94."

Amount in Dispute: $416.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Grapevine failed to provide any sufficient reasoning why it is entitled to additional reimbursement or how the limited documentation submitted justifies additional payment."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2017	L8699	$416.94	$416.94

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the reimbursement guidelines for ambulatory surgical centers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
   - 983 – Charge for this procedure exceeds Medicare ASC schedule allowance
   - 851 – The allowance was adjusted in accordance with multiple procedure rules and/or guidelines
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained

- 6981 – Charges for surgical implants are reviewed separately by ForeSight Medical.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $416.94 for the implants that were provided as part of professional medical services performed in an Ambulatory Surgical Center on January 12, 2017.

   The insurance carrier denied disputed services with claim adjustment reason code 6981 – "Charges for surgical implants are reviewed separately by ForeSight Medical."

   28 Texas Administrative Code §134.402 (f) (B) (i) states in pertinent part,

   > Reimbursement for non-device intensive procedures shall be:
   >
   > (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 service in dispute will be reviewed per the fee guideline referenced above.

2. Review of the submitted documentation found the following:

Product Name	Manufacturer	Invoice Amount	Reimbursement Calculation
Posterior Tibielis Tendon	Musculoskeletal Transplant Foundation	$1,517.00	$1,517.00 x 10% = $151.70 = $1,517 = $1,668.70
UC Acufex Director elite drill guidey sys	smith&nephew	$400.00	$400.00 x 10% = $40.00 + $400.00 = $440.00
Ultrabutton Adjustable Fixation Device	smith&nephew	$1,005.00	$1,005.00 x 10% = $100.50 + $1,005.00 = $1,105.50
Endobutton CL Ultera PAC 1.2	smith&nephew	$331.76	$331.76 x 10% = $33.18 + $331.76 = $364.94
Screw Biosure regenesorb 10mm x 30mm	smith&nephew	$599.00	$599.00 x 10% = $59.90 + $599.00 = $658.90
	Total	$3,852.76	$4,238.04

   The applicable fee guideline calculation of the allowable is $4,238.04.

3. The allowed amount for the services in dispute is $4,238.04. The carrier paid $3,821.10. The remaining balance of $416.94 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $416.94.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable) the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $416.94, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

		August 4, 2017
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 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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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 Texas Administrative Code §141.1(d).

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