



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Heritage Park Surgery Center

**Respondent Name**

Texas Municipal League Intergovernmental

**MFDR Tracking Number**

M4-24-2608-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

July 29, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2023	L8699	\$11,131.12	\$0.00
<b>Total</b>		\$11,131.12	\$0.00

### Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document titled "Reconsideration" dated July 19, 2024 that states, "Per TX Rule134.402, implants should be reimbursed at manual cost plus 10% and implant invoices are enclosed for review."

**Supplemental response September 5, 2024**

"No please continue with dispute due to balance still owed."

**Amount in Dispute:** \$11,131.12

### Respondent's Position

"The provider is requesting additional payment for implants billed with CPT code L8699-2 units in the amount of \$10,119.20. It was determined that the provider corrected the UB-04 REV Code-278 description of implant on the request for reconsideration UB-04, but the itemized statement still indicated that REV Code 278 – L8699 was billed Allosync CB DBM Past 8C (1 unit) and Allograft FQL 9571 Presu (1 unit). The operative report documents only 1 Allograft was used. Therefore, the carrier is allowing an additional amount for the Allograft only and invoice cost of \$2470 +10% plus interest."

**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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.403](#) sets out requirements of implant reimbursement.

### Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 252 – An attachment other documentation is required to adjudicate this claim/service.
- 253 – In order to review this charge please submit a copy of the certified invoice.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- 790 – The charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: Provider requested implant reimbursement/missing L8699 invoices.

### Issues

1. Did the requestor support the cost of the implants?

### **Findings**

1. The requestor is seeking additional reimbursement for implants billed as part of an outpatient surgery rendered in November 2023. The insurance carrier made a payment of \$2,787.17 on August 20, 2024 for Allograft FQL09571. The remaining implant submitted under Code L8699 was denied for lack of documentation.

DWC Rule 28 TAC §134.403 (g) states, "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at 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."

Review of the submitted documentation found insufficient evidence to support the cost of Allosync CB DBM Paste. No payment is recommended.

### **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**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

September 13, 2024  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).