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
Baylor Orthopedic & Spine Hospital

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-25-1108-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
January 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2024	L8699	$1,081.30	$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 December 11, 2024 that states, "Per EOB received, CPT code L8699 was underpaid. Please note per TX Rule 134.402, implants should be reimbursed at manual cost plus 10%."

Amount in Dispute: $1,081.30

Respondent's Position

The Austin carrier representative for TASB Risk Management Fund is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 4, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available

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 the billing and reimbursement of outpatient hospital services.

Denial Reasons

- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 353 – This charge was reviewed according to the submitted invoice and documentation.
- 95 – Plan procedures not followed.
- U03 – There was no UR procedure/treatment request received.
- U03 – The billed service was reviewed by UR and authorized.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 350 – Bill has been identified, as a request for reconsideration or appeal.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- W3 – In accordance with TDI-DWC Rule 134,804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the requestor support the cost of the implants in compliance with applicable DWC rule?

Findings

1. The requestor is seeking additional payment of code L8699 – Prosthetic implant not otherwise specified. The insurance carrier made a payment of $2,181.30.

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (g) 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 the following.

   - Arthrex Sales order dated July 19, 2024 that states, "This is not an invoice."
   - Screen Shot of Materials Mgmt: Item Inquire

   These items are not the manufacturer's invoice. Therefore, no calculation of the maximum allowed reimbursement is possible. 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 entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 16, 2025 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.