



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Memorial Hermann Surgical Hospital

**Respondent Name**

Standard Fire Insurance

**MFDR Tracking Number**

M4-26-0850-01

**Insurance Carrier's Austin Representative**

BOX 5 Travelers Co Inc

**DWC Date Received**

November 21, 2025

### Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
September 2, 2025	29882	\$0.00	\$0.00
September 2, 2025	L8699	\$3,025.77	\$0.00
<b>Total</b>		\$257.34	\$0.00

### Requester's Position

"The attached claim was processed and paid incorrectly... This clean claim was billed requesting the surgical procedure be paid at 130% of CMS with separate reimbursement for our implants. 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.' The following is a breakdown of how this claim should have processed ...

CPT 29882 allows \$3731.31 (pays @ 130%) = \$3731.31

CPT L8699 allows \$2750.70 (cost)+ \$275.07 (10% interest)= \$3025.77

Claim Allowed Total= \$6757.08

Less Payment of \$6499. 74

We are owed an additional payment of \$257.34.”

**Amount In Dispute:** \$257.34

### **Respondent's Position**

“The Provider originally submitted the billing without requesting separate reimbursement for the implantables. Consequently, the admission was reimbursed at 200% of the base Medicare rate or \$6,499.74. Please note the Carrier originally miscalculated the reimbursement at \$6,757.08, resulting in an overpayment of the Maximum Allowable Reimbursement. The Provider is now seeking separate reimbursement for the implantables, so the conversion factor changes to 130% or \$4,224.83. This results in an overpayment of the procedure code... The new Maximum Allowable Reimbursement for the admission is \$4,224.83 (the procedure) plus \$1,413.50 (the implantables) for a total of \$5,638.33. As this is less than the \$6,499.74 already reimbursed, no additional reimbursement is due.”

**Response Submitted By:** Travelers

### **Findings and Decision**

#### Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers’ Compensation (DWC).

#### Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.403](#) sets out the guidelines for outpatient hospital services.
3. [28 TAC §133.10](#) sets out required billing forms/formats for health care provider billing procedures.

#### Adjustment Reasons

1. 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
2. 4915 – THE CHARGE FOR THE SERVICES REPRESENTED BY THE CODE IS INCLUDED/BUNDLED INTO THE TOTAL FACILITY PAYMENT AND DOES NOT WARRANT A SEPARATE PAYMENT OR THE PAYMENT STATUS INDICATOR DETERMINES THE SERVICE IS PACKAGED OR EXCLUDED FROM PAYMENT.

#### Issues

1. What is DWC considering in this medical fee dispute?

2. Did the requestor, Memorial Hermann Surgical Hospital, request separate reimbursement for the disputed surgical implantable items in accordance with DWC Rules?
3. Is the requester entitled to additional reimbursement?

## Findings

1. This medical fee dispute involves surgical services rendered on September 2, 2025, in an outpatient surgical facility setting.

According to the submitted DWC Form-060, *Medical Fee Dispute Resolution Request* (DWC Form-060), two procedure codes are listed in the Table of Disputed Services: CPT code 29882 and CPT code L8699. However, the amount in dispute for CPT code 29882 is \$0.00. Therefore, CPT code 29882 will not be considered in this medical fee dispute resolution (MFDR) review.

The only remaining procedure code in dispute, CPT code L8699, represents a surgical implant product and is in dispute for an additional reimbursement amount of \$257.34. This is the only procedure code to be considered in this MFDR review.

2. The requester is seeking additional reimbursement for surgical implant products provided in an outpatient hospital setting on September 2, 2025.

The insurance carrier denied payment for the implantable items with denial reasons defined above, indicating that payment for the disputed service was included in the payment of another procedure/service provided on the same date.

Additionally, the insurance carrier's response asserts that there was no request on the medical bill for separate implant reimbursement.

28 TAC §134.403, which sets out fee guidelines for outpatient hospital services, states in pertinent part, "(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant **provider requests separate reimbursement in accordance with subsection (g) of this section**, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(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-ons per admission."

28 TAC §133.10, which sets out required medical billing forms/formats, states in pertinent part, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form..."

(2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care: ...

**(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested."**

A review of the submitted medical bills finds no evidence that the health care provider requested separate reimbursement on the medical bill for implants on the disputed date of service. Therefore, DWC finds that Memorial Hermann Surgical Hospital did not request separate payment for surgical implantable items in accordance with DWC Rules 28 TAC §134.403 and 28 TAC §133.10.

3. The requestor is seeking additional reimbursement in the amount of \$257.34 for surgical implantable products provided in an outpatient hospital setting on September 2, 2025.

Because the health care provider did not request separate reimbursement in accordance with 28 TAC §134.403 and 28 TAC §133.10, for the disputed implantable items, DWC finds that the requester is not entitled to additional reimbursement for the disputed date of service.

### Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

## Authorized Signature

\_\_\_\_\_  
Signature

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

January 14, 2026

\_\_\_\_\_  
Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).