TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Occu-Health Surgery Center

Respondent Name
XL Specialty Insurance Co.

MFDR Tracking Number
M4-25-1503-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 28, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 14, 2024	26785	$23,284.00	$0.00
November 14, 2024	11760	$5,081.00	$0.00
	Total	$28,465.00	$0.00

Requestor's Position

"The operative report indicates the … was repaired. It is written in the last paragraph. The denial reason is not substantiated. 11760 …

"code 26785 is described in the op note and there are no ncci edit conflicts with any of the other procedures…"

Amount in Dispute: $28,465.00

Respondent's Position

"As CorVel has now determined the Requestor has provided evidence of their due diligence in submitting the medical billing in question for date of service 11/14/[24] with supporting documentation. Additional payment has been made and includes interest. A copy of the explanation of benefits has been attached and the check information is below."

Response submitted by: Corvel

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 §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §124.2 sets out Insurance Carrier Notification Requirements.
4. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Adjustment Reasons

According to the most current explanation of benefits (EOB) submitted by the respondent, dated March 31, 2025, the insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 00 - CCI Edit reviewed and suppressed
- 97A - Provider appeal
- P12 - Workers' Compensation State Fee Schedule Adj
- ZZ - Timely Filing rule reviewed and suppressed
- 59 - Allowance based on Multiple Surgery Guidelines
- ET - Emergency Services
- RD7 - Multiple Procedure/1st Procedure
- RD9 - Multiple Procedure/3rd or Subsequent (50%)

Issues

1. As of the date of this review, what is the total amount of reimbursement that has been allowed for the services rendered on the disputed date, November 14, 2024?
2. What rule applies for determining the reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement for the disputed service billed under CPT code 26785?
4. Is the requestor entitled to additional reimbursement for the disputed service billed under CPT code 11760?

Findings

1. This medical fee dispute involves the reduced payment for surgical services rendered to an injured employee in a licensed ambulatory surgical center on November 14, 2024.

   A review of the submitted EOB dated January 16, 2025, finds that the insurance carrier initially allowed reimbursement in the total amount of $7,248.95, for services rendered on November 14, 2024. This original EOB allowed reimbursement in the amount of $0.00 for the disputed CPT codes 26785 and 11760. DWC finds that these are the only procedure codes in dispute and therefore, these are the only procedure codes to be reviewed in this medical fee dispute resolution (MFDR).

   Upon reconsideration and re-evaluation, the respondent, Corvel, recommended additional reimbursement noting in its response position statement, "upon removal of the NCCI OCE edit, it was determined that 26785 is the first level code paid at full fee schedule and 26433 is now paid at 50% of fee schedule as per the multiple procedure rule."

   A review of the re-evaluation EOB dated March 31, 2025, finds that the procedure codes in dispute have been allowed reimbursement as follows:

   - CPT code 26785 was allowed reimbursement in the amount of $3,573.69.
   - CPT code 11760 was allowed reimbursement in the amount of $146.47.

   A review of the submitted documentation further finds that the insurance carrier issued additional payment to the requestor by check on March 31, 2025, in the amount of $1,955.46 which included an interest payment amount of $22.14. Therefore, DWC finds that the additional reimbursement amount allowed for services rendered on November 14, 2024, was $1,933.32.

   DWC finds that as of the date of this review, the requestor has been reimbursed in the total amount of $9,182.27 plus interest for services rendered on the disputed date November 14, 2024.

2. A review of the submitted documentation finds that this medical fee dispute involves reduced payment for services rendered in a licensed ambulatory surgical center on November 14, 2024.

   DWC finds that Rule 28 TAC §134.402 applies to the reimbursement of the services in dispute.

   DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor-related share.

DWC Rule 28 TAC §134.402 (f) states in pertinent part "the reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register…
(1) Reimbursement for non-device intensive procedures shall be:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
(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; and
(ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

A review of the submitted medical bills finds that the facility did not request separate reimbursement for surgical implantables in this case.

3. The requestor, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $23,384.00 for procedure code 26785 rendered on November 14, 2024. As noted in finding number one, CPT code 26785 has been allowed reimbursement in the amount of $3,573.69 as of the date of this review.

   CPT code 26785 is described as "Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single."

   Procedure Code 26785 has a payment indicator of A2 indicating that payment is based on OPPS relative payment weight. DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part "reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent." The following formula is used to calculate the MAR:

   - The Medicare ASC reimbursement for code 26785 on the applicable date of service is $1,518.75.
   - The Medicare ASC reimbursement is divided by 2 = $759.375.
   - This number multiplied by the CBSA index of 1.0026, for Houston-The Woodlands-Sugar Land, TX region = $761.349.
   - Add these two together = $1,520.724, which is the geographically adjusted Medicare ASC rate.
   - To determine the MAR for CPT 26785, multiply the geographically adjusted Medicare ASC rate of $1,520.724 by the DWC payment adjustment factor of 235% = $3,573.70.
   - DWC finds that the MAR for CPT code 26785 rendered on November 14, 2024, is $3,573.70.
   - The insurance carrier allowed $3,573.69.

- Additional reimbursement is not recommended for CPT code 26785 rendered on November 14, 2024.

4. The requestor, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $5,081.00 for procedure code 11760 rendered on November 14, 2024.

   CPT code 11760 is described as "Repair of … ; simple, single." Procedure Code 11760 has a payment indicator of P3 indicating an office-based surgical procedure added to the ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) non-facility PE RVUs; payment is based on MPFS non-facility PE RVUs. However, in accordance with DWC Rule 28 TAC §134.402 (f), reimbursement shall be based on the Medicare ASC facility reimbursement amount multiplied by 235 percent. Per the ASC Addendum AA for the applicable date of service, the Medicare facility reimbursement amount is $124.49.

   Per the ACS addendum AA for the applicable date of service, DWC finds that CPT code 11760 is subject to the Medicare multiple procedure payment reduction (MPPR) rule. A review of the Medicare Claims Processing Manual – Chapter 14, Section 40.5 – Payment for Multiple Procedures, finds that when more than one surgical procedure is performed in the same operative session, special payment rules apply. When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

   Per CMS, multiple surgeries are reimbursed as follows:

   - 100 percent of the fee schedule amount for the highest valued procedure; and
   - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures

   DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part "reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent." The following formula is used to calculate the MAR:

   - The Medicare ASC reimbursement for code 11760 for applicable date of service is $124.49.
   - The Medicare ASC reimbursement is divided by 2 = $ 62.245.
   - This number multiplied by the CBSA index of 1.0026, for Houston-The Woodlands-Sugar Land, TX region = $62.407.
   - Add these two together = $124.652, which is the geographically adjusted Medicare ASC rate.
   - To determine the MAR for CPT 11760, multiply the geographically adjusted Medicare ASC reimbursement of $124.652 by the DWC payment adjustment factor of 235% = $292.932.
   - Because this procedure was furnished in the same session as another primary procedure, CPT code 11760 is subject to MPPR discounting; therefore, the MAR is

fifty percent of $292.932, or $146.47.

- The insurance carrier paid $146.47.
- Additional reimbursement is not recommended for CPT code 11760 rendered on November 14, 2024.

DWC finds that the requestor is not entitled to additional reimbursement for CPT code 11760 rendered on November 14, 2024.

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 requestor has not established that additional reimbursement is due.

ORDER

Under Texas Labor Code §§413.031, DWC has determined the requestor is entitled to additional reimbursement in the amount of $0.00 for the disputed services rendered on November 14, 2024.

Authorized Signature

		June 18, 2025
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 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.