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
Complete Surgery
Mesquite

Respondent Name
Hartford Underwriters Insurance Co.

MFDR Tracking Number
M4-25-1827-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
April 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 18, 2024	24358	$1,428.81	$1,428.42

Requestor's Position

"...the amount allowed and paid is less than the fee schedule. It appears Hartford calculated the allowed rate at 153% of Medicare instead of 235% of Medicare as the claim was billed."

Amount in Dispute: $1,428.81

Respondent's Position

"Bill was reprocessed and paid on 2/18/25 under control numbers 902123827. Bill paid based on surgical center rate schedule in the amount of $2073.72."

Response submitted by: The Hartford

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 §134.402 sets out the fee guidelines for ambulatory surgical centers.

Adjustment Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- 183 - REIMBURSEMENT BASED ON SURGICAL CENTER RATE SCHEDULE.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 1001 -BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

Issues

1. What Rule applies to the reimbursement of the service in dispute?

2. Is the requestor entitled to additional reimbursement for the disputed service?

Findings

1. This medical fee dispute involves facility charges for surgical services rendered in a licensed ambulatory surgical center. The requestor, Complete Surgery Mesquite, is requesting additional reimbursement for surgical procedure code 24358.

   DWC Rule 28 TAC §134.402 (d), which applies to the disputed service, 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 maximum allowable reimbursement (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.

Reimbursement shall be based on the fully implemented payment amount published in the Federal Register. Reimbursement for non-device intensive procedures shall be the sum of the ASC device portion and the ASC service portion multiplied by 235 percent.

2. The requestor is seeking additional reimbursement in the amount of $1,428.81 for procedure code 24358 rendered on November 18, 2024, in a licensed ambulatory surgical center. On the disputed date of service, the requester billed for one unit of procedure code 24358-RT in addition to other related surgical procedures and supplies. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) request form finds that 24358 is the only procedure code in dispute. Therefore, only procedure code 24358 will be reviewed in this MFDR process.

   In accordance with 28 TAC §134.402, the MAR for the service in dispute is calculated as follows:

   Procedure Code 24358 has an ASC payment indicator of G2 which indicates a non-office based surgical procedure; payment is based on OPPS relative payment weight. This disputed procedure code is non-device intensive.

   28 TAC §134.402 (f) states in pertinent part, "(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-ons per admission; and
   (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

The following formula is used to calculate the MAR for the non-device intensive procedure code 24358 rendered on November 18, 2024:

- Per Addendum AA, the Medicare ASC reimbursement rate for code 24358 for CY 2024 is $1,518.75.
- The ASC reimbursement rate $1,518.75 is divided by 2 = $759.375.
- The CBSA for the Dallas, Texas region is 0.9625. Fifty percent of the ASC reimbursement rate, $759.375, is multiplied by 0.9625 = $730.898.
- The sum of these two, $759.375 + $730.898, is the geographically adjusted Medicare (MC) ASC reimbursement = $1,490.273.
- Multiply the geographically adjusted MC rate of $1,490.273 by the DWC payment adjustment of 235% = $3,502.14 MAR

DWC finds the MAR for the disputed CPT code 24358-RT, rendered on November 18, 2024, is $3,502.14. A review of the explanation of benefits submitted finds that the insurance carrier paid $2,073.72. Therefore, additional reimbursement in the amount of $1,428.42 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 requestor has established that additional reimbursement is due in the amount of $1,428.42.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Hartford Underwriters Insurance Co. must remit to Complete surgery Mesquite $1,428.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 2, 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.