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

General Information

Requester Name
Occu-Health Surgery Center

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-25-3317-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 18, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 6, 2025	35206	$6,491.00	$0.00

Requester's Position

"CPT 35207 (procedure description) is listed on the CMS ASC fee schedule and is payable. Because the … artery at the … supplies only the …, the work and clinical impact are equivalent to a … repair. Reimbursement for 35206 should therefore be aligned with 35207 or equivalent … repair codes that CMS already recognizes as payable in the ASC setting."

Excerpt from the Supplemental Position statement via electronic correspondence dated September 10, 2025: "While ASC reimbursement is structured around the facility's resources, the specific CPT-coded physician work directly dictates the intensity, equipment, staffing, and risk profile of the procedure performed in the ASC… Without recognition of CPT 35206, the ASC is uncompensated for major facility expenditures directly attributable to the vascular repair."

Amount in Dispute: $6,491.00

Respondent's Position

"We are standing on our original denial position under TSTX-574091 as the bill was billed as an ASC with the POS 24."

Response submitted by: Enlyte

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

- H95 - BASED ON MEDICARE GUIDELINES, THIS SERVICE IS NOT CONSIDERED APPROPRIATE TREATMENT TO BE PERFORMED IN AN ASC SETTING.
- 58 - TREATMENT WAS DEEMED BY THE PAYER TO HAVE BEEN RENDERED IN AN INAPPROPRIATE OR INVALID PLACE OF SERVICE.
- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 432 - A COMPREHENSIVE CCI CODE HAS BEEN PAID ON A BILL IN PERMANENT HISTORY THAT SHOULD HAVE BEEN BUNDLED.
- 351 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What rule applies for determining the reimbursement for the disputed services?
2. Is the insurance carrier's reason for denial of CPT code 35206-LT-ET supported?
3. Is the requester entitled to reimbursement for the disputed service billed under CPT code 35206-LT-ET?

Findings

1. A review of the submitted documentation finds that this medical fee dispute involves non-

payment for a surgical service billed under CPT code 35206-LT-ET, rendered in a licensed ambulatory surgical center (ASC) on February 6, 20025.

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, specifically Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers. Per section 30, 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. Furthermore, per Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers, section 40.5, when more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the procedures have the same HCPCS code. 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. The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

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.

DWC Rule 28 TAC §134.402 (i) states, "If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

(1) The agreement may occur before, or during, preauthorization.

(2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(5) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division."

2. The requester, a licensed ambulatory surgical center (ASC), is seeking reimbursement in the amount of $6,491.00 for surgical procedure code 35206-LT-ET rendered on February 6, 2025.

   A review of the submitted medical bill finds that the requester billed for surgery services rendered on the disputed date under CPT codes 25608-LT-ET, 76000-59-26-ET, and 35206-LT-ET.

   A review of the submitted EOB documents finds that surgical procedure codes 25608-LT-ET and 76000-59-26-ET have previously been allowed reimbursement in the total amount of $7,374.87 as of the date of this review and these CPT codes are not in dispute.

   Per the submitted EOBs, the insurance carrier denied reimbursement for the disputed CPT code 35206-LT-ET with a denial based on the service is not an appropriate treatment to be performed in an ASC setting according to Medicare Guidelines.

   A review of the 2025 Medicare ASC Addendum AA, which contains the covered ASC surgical procedures for CY 2025, finds that CPT 35206 is absent from the list of covered ASC procedures. A review of the 2025 Addendum EE, which contains the final surgical procedures to be excluded from payment in ASCs for CY 2025, finds that CPT code 35206 is listed as an excluded ASC procedure. As a result of applicable Medicare ASC Addenda reviews and in accordance with 28 TAC §134.402, DWC finds that CPT code 35206 is not payable when performed in an ASC setting.

   A review of the submitted documentation finds no evidence of a voluntary agreement between the insurance carrier, health care provider, and ASC that would allow the procedure represented by CPT code 35206 to be reimbursed when performed in the ASC setting on the disputed date of service, in accordance with 28 TAC §134.402 (i).

   DWC finds that the insurance carrier's reason for denial of CPT code 35206-LT-ET rendered on February 6, 2025, is supported.

3. The requester, a licensed ambulatory surgical center, is seeking reimbursement for the disputed procedure code 35206-LT-ET, rendered on February 6, 2025. Because the insurance carrier's reason for denial is supported, reimbursement is not recommended.

   DWC finds that the requester is not entitled to reimbursement for CPT code 35206-LT-ET, rendered on February 6, 2025.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 reimbursement is due.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to reimbursement in the amount of $0.00 for the disputed service.

Authorized Signature

		November 24, 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.