



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Momentum Specialty Surgery Center

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-26-0012-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

September 3, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2025	27385-RT	\$6,194.47	\$4,978.87
Total		\$6,194.47	\$4,978.87

Requester's Position

"Line item 27385/RT is not reimbursed correctly according to the Texas ASC fee schedule. The charges on this bill should be reimbursed according to the Global reimbursement method because the provider billed Globally and did not request separate payment for the Implants. The carrier paid using the Separate methodology in error."

Amount In Dispute: \$6,194.47

Respondent's Position

"We have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

Response Submitted By: Gallagher Bassett

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 [134.402](#) sets out the guidelines for ambulatory surgical centers.
3. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. P12 & 90223 – Workers' compensation jurisdictional fee schedule adjustment.
2. 4063 – REIMBURSEMENT BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING.
3. 5406 -RECONSIDERATION, ADDITIONAL ALLOWANCE RECOMMENDED. THIS BILL AND SUBMITTED DOCUMENTATION HAVE BEE RE-EVALUATED BY CLINICAL EVALUATION.
4. 90121 – CHARGES ARE ADJUSTED BASED ON MULTIPLE SURGERY RULES OR CONCURRENT ANESTHESIA RULES.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. What is the maximum allowable reimbursement (MAR) for the services in question?
4. Is the requester entitled to additional reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) review involves reduced payment for surgery services rendered in a licensed ambulatory surgical center (ASC) on April 29, 2025. Specifically, the procedure code in dispute is CPT code 27385-RT.

In its response, Gallagher Bassett stated it will provide a supplemental response after the audit review is completed. DWC notes that as of the date of this review, a supplemental response has not been submitted.

A review of the submitted medical bill finds that on the date of service in dispute the requester billed one unit each of CPT surgical codes 27385-RT and 64447-XU and billed two

units of CPT code C1713 which represents surgical implantable products.

DWC notes that separate reimbursement for surgical implants was not requested on the medical bill.

A review of the submitted explanation of benefits (EOB) dated July 7, 2025, finds that the insurance carrier allowed reimbursement for CPT code 27385-RT in the amount of \$1,579.95, allowed \$82.28 for CPT code 64447 and allowed reimbursement in the amount of \$1,251.26 for two units of CPT code C1713. DWC finds that as of the date of this review, the insurance carrier has allowed reimbursement in the total amount of \$2,913.49 for surgical services rendered on April 29, 2025.

The requester is seeking additional reimbursement in the amount of \$6,194.47. DWC will review the surgical services rendered on April 29, 2025, in accordance with applicable Statutes and Rules to determine if additional reimbursement is due to the requester.

2. Because this MFDR review involves services rendered in a licensed ASC, DWC finds that Rule 28 TAC Section 134.402 applies to the reimbursement of the services in dispute.

DWC Rule 28 TAC Section 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 Section 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. As a result, DWC will not include surgical implant products in the calculation of the MAR for the disputed date of service.

3. The requester, a licensed ambulatory surgical center, is seeking additional reimbursement in the amount of \$6,194.47 for surgical procedure code 27385-RT rendered on April 29, 2025.

Procedure code 27385 is described as "Suture of quadriceps or hamstring muscle rupture; primary". Per 2025 ASC Addendum AA CPT code 27385 has a payment indicator of A2 indicating a surgical procedure on the ASC list in CY 2007; payment is based on OPPS relative payment weight.

Procedure code 64447 is described as "Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed". Per 2025 ASC Addendum AA CPT code 64447 is assigned a payment indicator P3, which indicates an Office-based surgical procedure added to 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.**

DWC finds that both procedure codes billed on April 29, 2025, are subject to the Medicare multiple procedure payment discounting 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 finds that CPT code 27385 is the highest valued procedure billed on the disputed date of service. Therefore, CPT code 27385 will receive 100 percent of the Medicare fee schedule amount while CPT code 64447 will receive 50 percent of the MPFS non-facility payment amount.

DWC Rule 28 TAC Section 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 **CPT code 27385** on the applicable date of service is \$3,510.84.
- The Medicare ASC reimbursement is divided by 2 = \$1,755.42.
- This number multiplied by the 2025 CBSA index of 0.8846, for Wichita Falls, TX = \$1,552.845.
- Add these two figures together = \$3,308.265, the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT code 27385, multiply the geographically adjusted Medicare ASC reimbursement of \$3,308.265 by the DWC payment adjustment factor of 235% = \$7,774.4223.
- DWC finds that the **MAR for the disputed CPT code 27385-RT is \$7,774.42.**
- The Medicare MPFS non-facility payment amount for **CPT code 64447** on the disputed date of service is \$108.71.
- DWC Rule 28 TAC Section 134.402(h) states, for medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.
- DWC Rule 28 TAC Section 134.203(c)(1) states in pertinent part, to determine the maximum allowable reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is the conversion factor applicable to the disputed date of service.
- To determine the MAR the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.
- The disputed service was rendered in zip code 76310, locality 99, "Rest of Texas"
- The non-facility Medicare participating amount for CPT code 64447 on the disputed date of service at this locality is \$108.71.
- Because the procedure was performed in the same session as another primary procedure, CPT code 64447 receives 50 percent of the Medicare non-facility amount or \$54.36.

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor on the applicable date of service is 32.3465.
- Using the above formula, DWC finds the **MAR is \$117.94 for CPT code 64447** on the disputed date of service.

DWC finds that the total MAR for surgical services rendered on April 29, 2025, in an ASC facility setting is \$7,892.36.

4. The requester, a licensed ASC facility, is seeking additional reimbursement in the amount of \$6,194.47 for surgical services rendered on April 29, 2025.

As demonstrated in finding number three, DWC finds that the total MAR for the disputed surgical services rendered on April 29, 2025, is \$7,892.36.

Per the EOBs submitted, the insurance carrier has previously paid \$2,913.49. Additional reimbursement in the amount of \$4,978.87 is recommended.

DWC finds that the requester is entitled to additional reimbursement in the amount of \$4,978.87.

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 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 additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Company must remit to Momentum Specialty Surgery Center \$4,978.87 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

		February 18, 2026
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 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. 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.

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.