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

General Information

Requestor Name
Gulf Coast Orthopaedic & Spine

Respondent Name
Bitco General Insurance Corp.

MFDR Tracking Number
M4-25-0161-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 16, 2024

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2024	11012	$3,321.00	$1,111.40

Requestor's Position

"EOB explanation codes to deny 11012 (236) does not apply. This was an (redacted) as per the OP note and diagnosis. The NCCI edits do not bundle 11012 with any of these other codes. AMA CPT published guidelines for the current year also distinguish open fracture debridement (11012) as a separate procedure from the other codes billes [billed]. The work to debride the wound bed was separate from the other CPTs and needs to be paid."

Amount in Dispute: $3,321.00

Respondent's Position

The Austin carrier representative for Bitco General Insurance Corp. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on September 24, 2024. Per 28 Texas Administrative Code §133.307 (d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 §134.203 sets out the fee guideline for professional medical services.

Adjustment Reasons

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

- 236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.
- R09 – CCI: CPT Manual and CMS coding manual instructions.
- W3 – Appeal/Reconsideration.

Issues

1. What rules apply to the services rendered in this medical fee dispute?
2. Is the insurance carrier's reason for reimbursement denial of CPT code 11012 supported?
3. Is the requestor entitled to reimbursement for disputed CPT code 11012?

Findings

1. This medical fee dispute resolution (MFDR) request involves services rendered by a medical doctor in an ambulatory surgical center facility on March 18, 2024. The only service specifically in dispute is CPT code 11012, described as "a surgical procedure of debridement, specifically involving the removal of necrotic tissue and foreign materials from the site of an open fracture and/or open dislocation."

   On the disputed date of service, the requestor also billed CPT codes 26765-59 and 13131-59. Procedure code 26765 is described as "a surgical procedure that involves the open treatment of a distal phalangeal fracture in either a finger or thumb." Procedure code 13131 is described as "the complex repair of wounds located on the forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet, specifically for wounds measuring between 1.1 cm to 2.5 cm." The requestor appended these two CPT codes with modifier "59" to indicate the service was distinct or independent from other services rendered on the same date.

DWC finds that 28 TAC §134.203 applies to the billing and reimbursement of the disputed service. 28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

2. A review of the submitted explanation of benefits finds that the insurance carrier reimbursed the requestor for CPT codes 26765-59 and 13131-59 but denied payment for CPT code 11012 billed on the same date of service. Reimbursement was denied for CPT code 11012 based on National Correct Coding Initiative (NCCI) edit conflicts.

   DWC ran NCCI edit checks for the three codes billed together on the disputed date of service and found no conflicts.

   In addition, Medicare Article - Billing and Coding: Wound Care (A53001) states in pertinent part, "… debridement of tissue at the site of an open fracture or dislocation may be reported separately with CPT codes 11010-11012."

   A review of the submitted medical record finds that the documentation supports the billing and reimbursement of CPT code 11012 as a separate procedure. Therefore, DWC finds that the insurance carrier's reason for denial of the disputed CPT code 11012 is not supported.

3. The requestor is seeking reimbursement in the amount of $3,321.00 for CPT code 11012 rendered on March 18, 2024.

   Because the insurance carrier's reason for denial of procedure code 11012 rendered on March 18, 2024, is not supported, DWC finds that the requestor is entitled to reimbursement in accordance with the applicable Rule 28 TAC §134.203.

   28 TAC §134.203(c) 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. (1) 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 $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year."

   To determine the MAR the following formula is used:
   (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

- The disputed services were rendered in zip code 77027, locality 18, "Houston."
- The Medicare participating amount for CPT code 11012 in 2024, rendered in a facility setting at this locality is $434.63.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, March 18, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $1,111.40 for CPT code 11012 on March 18, 2024, rendered in a facility setting in locality 18.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $1,111.40 is recommended for CPT code 11012 rendered on March 18, 2024, in a facility setting.

DWC finds that the requestor is entitled to reimbursement in the amount of $1,111.40 for CPT code 11012 rendered in an ambulatory surgical center in locality 18, on March 18, 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 established that reimbursement is due in the amount of $1,111.40.

ORDER

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed service. It is ordered that the Respondent, Bitco General Insurance Corp., must remit to the Requestor, Gulf Coast Orthopaedic & Spine, $1,111.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 23, 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.