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
Edward Lee MD

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-25-0424-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 21, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 2, 2023	11012	$1458.45	$0.00
November 2, 2023	13132	$1082.13	$0.00
November 2, 2023	99205	$569.28	$0.00
	Total	$3,109.86	$0.00

Requestor's Position

The submitted request for MFDR did not contain a position statement. The reconsideration included with this dispute states, "I would like to appeal the decision to not pay or underpay for the following: 1) CPT 11012 - …This was an (redacted) with associated (redacted). Debridement of such (redacted) is standard care. No specific treatment on the (redacted) was performed; as such, the procedure was coded as debridement only. 2) CPT 13132 - …this was separate and necessary part of patient's overall surgery. 3) CPT 99205 – we INCORRECTLY coded for wrong place of services along with service facility. Please find attached revised claim form with the correct coding. This office visit was DISTINCT AND SEPARATE from the surgical procedure performed on the same day."

Amount in Dispute: $3,109.86

Respondent's Position

The Austin carrier representative for Arch Insurance Co is Flahive, Ogden & Latson. The

representative was notified of this medical fee dispute on October 29, 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 (TLC) §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) §134.203 sets out the procedures for billing and payment of professional medical services.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that (illegible) already been adjudicated.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- P12/90223 – Workers' compensation jurisdictional fee schedule adjustment.
- B13 – Previously paid, payment for this claim/service have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- 00663 – Reimbursement has been calculated according to state fee guidelines.
- 231/90573 – Mutually exclusive procedures cannot be done in the same day/setting.
- 31029 – Per CPT code description, debridement code is only allowed for open fractures or dislocations. Service included in another code billed on the same day.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 59/90121 – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 6189 – In accordance with clinical based coding edits (National Correct coding initiative/outpatient code editor), component code of comprehensive surgery: Integumentary system procedure (10000-19999) has been disallowed.

- 78 – Non-covered days/room charge adjustment.

Issues

1. Is Arch Insurance Company's denial based on packaging and CCI edits supported?

Findings

1. The requestor is seeking reimbursement of the following.

   - 11012 – Debridement including removal of foreign material at the site on an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle and bone.

   - 13132 – Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm

   - 99205 – Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

   The insurance carrier denied code 11012 as service being included in another code billed on the same day and code 13132 based on national correct coding initiative edits.

   DWC Rule §134.203 (b)(1) states, (b) 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.

   Review of the applicable NCCI edits found the following. An unbundled relationship between code 11012 and 13132. Code 13132 had an unbundle relations with code 11760. Based on the application of the Medicare payment policy, the insurance carrier's denial is supported.

   Review of the Medicare National Correct Coding Initiative Policy Manual at www.cms.gov, Chapter XI, Section U states in pertinent part, *"Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intraprocedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A provider/supplier shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond*

the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure.

Procedure code 99205 has a global surgery of XXX. Therefore, as shown above the work associated with code 99205 should not have been reported as a separate E&M code without the appropriate modifier (25). Based on the submitted medical bill the insurance carrier's denial is supported, no payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Medical Fee Dispute Resolution Officer	January 31, 2025
Signature		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 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 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 tres o correo electronico CompConnection@tdi.texas.gov.