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

General Information

Requestor Name
Gulf Coast Orthopedics

Respondent Name
Old Republic Insurance Co.

MFDR Tracking Number
M4-25-1315-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
February 3, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 23, 2024	28485-T7	$2,893.00	$752.09

Requestor's Position

"This is an ongoing emergency medical condition since the time of injury and the following treatments were emergently indicated. Pre-authorization was not required and thus the denial code is not applicable (198) and (N54)."

Amount in Dispute: $2,893.00

Respondent's Supplemental Position

"After reviewing the bill, it is determined that the fee schedule is applied correctly."

Response submitted by: Gallagher Bassett

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.
3. 28 TAC §134.600 sets out the procedures for preauthorization requirements of healthcare services.
4. 28 TAC §133.2 sets out general rules and definitions for medical billing and processing.

Adjustment Reasons

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

- 198 - Precertification/notification/authorization/pre-treatment exceeded.
- N54 - Claim information is inconsistent with pre-certified/authorized services.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- W3 - In accordance with TTDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

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 28485-59-T7 supported?
3. Is the requestor's use of modifier "59" appended to the disputed procedure code supported?
4. Is the requestor entitled to reimbursement for disputed procedure code 28485-59-T7?

Findings

1. This medical fee dispute (MFDR) request involves services rendered by a medical doctor in an ambulatory surgical center facility on October 23, 2024.

   The only service specifically in dispute is CPT code 28485-59-T7, described as "Open treatment of metatarsal fracture, includes internal fixation, when performed, each."

   On the disputed date of service, the requestor also billed for procedure CPT code 28485-59-T6 on a separate line of service. The requestor appended both CPT codes with modifier "59" to

indicate the services were distinct or independent from other services rendered on the same date. Additionally, the requestor appended the codes with "T" modifiers indicating on which toe/digit each procedure was performed. Modifier "T6" indicates the toe (redacted), (redacted) and modifier "T7" indicates the toe (redacted).

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 (EOB) finds that the insurance carrier allowed reimbursement for all procedure codes on the disputed date of service except for procedure code 28485-59-T7, the only code in dispute. Denial of the disputed procedure code was based on lack of preauthorization and preauthorization exceeded.

   Per 28 TAC §134.600, which sets out preauthorization requirements of health care services, "(p) non-emergency health care requiring preauthorization includes: … (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   28 TAC §134.600 also states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions)."

   28 TAC §133.2 defines emergency as, "(5) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   The requestor asserts that the service in dispute was emergency treatment, thus exempt from required preauthorization. A review of the submitted documents finds the following statements as evidence to support that the disputed procedure was emergency medical treatment:

   - "If not for this procedure, THE PATIENT, was at increased risk of loss of function, loss of the BODY PART or OTHER complication including worsening pain or infection. Waiting for preauthorization or acceptance to an in-network provider would have put the patient at risk for further complications and potentially permanent damage with resultant loss of function."
   - "The patient presented to … Clinic with a … injury sustained at work today. The patient was complaining of severe pain, 8/10 to her [injured body part]."

- "The patient has sustained a severe acute injury to her … which will require immediate surgical intervention due to displacement of fracture fragments, high risk of infection, persistent pain, risk of permanent deformity to the … and limb loss."

DWC finds that the requestor's documentation supports that the disputed service rendered on the injured worker's date of injury [redacted], and billed under procedure code 28485-T7, was rendered as emergency medical treatment not requiring preauthorization. Therefore, DWC finds that the insurance carrier's reason for reimbursement denial of CPT code 28485-59-T7, based on lack of preauthorization, is not supported.

3. The requestor appended the disputed procedure code with modifier "59" which indicates that the procedure was a distinct or independent procedure from other procedures performed on the same date of service. According to Modifier 59 Fact Sheet, appropriate use of modifier "59" includes two procedures performed at separate anatomical sites on the same date of service. It is very important that medical records include documentation to support the use of modifier "59".

   A review of the operative report submitted finds documentation to support that the disputed procedure was performed on a separate anatomical site on the same date of service as other procedures performed and reimbursed on the same date. A review of the medical bill finds that modifier "T7" appended to procedure code 28485 accurately represents the digit to which the surgery was performed as described in the medical record. DWC concludes that the medical report supports the use of modifier "59" in billing for the disputed surgical procedure code 28485.

4. The requestor is seeking reimbursement in the amount of $2,893.00 for CPT code 28485-59-T7 rendered on October 23, 2024.

   Because the insurance carrier's reason for denial of procedure code 28485-59-T7, rendered on October 23, 2024, is not supported, and because the use of modifier "59" is supported in the medical record, 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."

DWC finds that on the disputed date of service, the requester also billed for surgical procedure code 28485-59-T6 in addition to the disputed code 28485-59-T7, both performed by the same surgeon.

A review of the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, section 40.6 - Claims for Multiple Surgeries, CMS defines multiple surgeries as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. 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

Medicare pays for multiple surgeries by ranking from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical code is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, the rank assigned by Medicare is reviewed for each surgery code.

CPT code 28485 has a multiple procedure status indictor of 2, which represents "standard payment adjustment rules for multiple procedures apply." In this circumstance, the same procedure code and rank applies to separate anatomical body parts. DWC finds that procedure code 28485-59-T6 was previously reimbursed at 100% of the MAR. The multiple procedure payment reduction (MPPR) applies; therefore, appropriate reimbursement for CPT code 28485-59-T7 is 50% of the MAR.

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 procedure code 28485 in October of 2024, rendered in a facility setting at this locality is $588.23.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, October 23, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $1,504.17 for procedure code 28485 on October 23, 2024, rendered in a facility setting in locality 18.
- The MPPR rate at 50% of the MAR is $752.09.
- The respondent paid $0.00 for this disputed procedure code.
- Reimbursement of $752.09 is recommended for procedure code 28485-59-T7 rendered on October 23, 2024, in a facility setting.

DWC finds that the requestor is entitled to reimbursement in the amount of $752.09 for

procedure code 28485-59-T7 rendered in an ambulatory surgical center in locality 18, on October 23, 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 $752.09.

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, Old Republic Insurance Co. must remit to the Requestor, Gulf Coast Orthopedics, $752.09 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 11, 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.