



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Gulf Coast Orthopedics

Respondent Name

Granite State Insurance Co

MFDR Tracking Number

M4-25-1369-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

February 3, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 27, 2024	11012	\$556.49	\$0.00
June 27, 2024	26765	\$24.56	\$0.00
Total		\$581.07	\$0.00

Requestor's Position

"EOB explanation codes to deny 11012 (XXEB6) does not apply as this WAS AN (Redacted) PER DOCUMENTATION AND ICD 10 CODE (Redacted). This was an (redacted) as per the OP note and diagnosis. The NCCI edits do not bundle any of these codes together. The work to debride the wound bed was separate from the other CPTs. FURTHER, THE RECOMMENDED ALLOWANCE CALCULATED FOR 26765 IS INCORRECT. PER THE MAR AND TWCC FEE SCHEDULE, IT IS \$1390.72.

Amount in Dispute: \$581.07

Respondent's Position

The Austin carrier representative for Granite State Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 25, 2025.

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 \(TAC\) §133.210](#) sets out requirement of medical documentation.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier made a reduction and denied the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 59 – Processed based on multiple or concurrent procedure rules
- XXE86 – CCR – Per CPT, this debridement code is only allowed for open fracture or dislocations
- XXG14 – Pricing is calculated based on the medical professional fee schedule facility site of service value
- XXJ16 – This procedure code was ranked as the primary service when considered for multiple procedure reduction. As a result no reduction was taken
- 95 – Plan procedures not followed
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Did the request for MFDR contain required documentation?

Findings

1. The requestor is seeking additional payment for services rendered in an ambulatory surgical center on June 27, 2024. The insurance carrier denied code 11012 as not payable and reduced the payment of code 26765 based on multiple procedure discounts. DWC Rule §133.307 (c)(2)(M) states in pertinent parts, "The requestor must send the request to the division in the form and manner prescribed by the division... ..The request must include a copy of all applicable medical records related to the dates of service in dispute.

DWC Rule §133.210 (c) (2) states in pertinent part, "In addition to documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds \$500: a copy of the operative report.

The information submitted with this request for MFDR did not contain an operative report. Based on this lack of information, 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

Signature

Medical Fee Dispute Resolution Officer

May 1, 2025

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 electrónico CompConnection@tdi.texas.gov.