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

General Information

Requestor Name
Jason R. Bailey, MD

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-25-1399-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 26, 2024	99223-ET	$787.60	$0.00
April 26, 2024	13131-ET-59-F8	$1,741.30	$0.00
April 26, 2024	76000-RT-59	$385.00	$0.00
April 26, 2024	11012-ET-F7-F8	$8,104.80	$1,111.40
April 26, 2024	29125-ET-59-RT	$580.00	$53.86
	Total	$11,598.70	$1,165.26

Requestor's Position

"Our claim was processed and denied incorrectly. Per the EOB received, code 99223 denied due: "No significant identifiable evaluation and management service has been documented". I am attaching a copy of Dr. Ashford's hospital consultation from date of service 04/26/24 dictating the work injury. Also, per the EOB, codes 11012, 13131, 29125 and 76000 all denied for "bundling", which they shouldn't as these were EMERGENCY SERVICES, indicated by the 'ET' modifier and the 'Y' in box 24C of our claim form."

Amount in Dispute: $11,598.70

Respondents' Position

"The provider has requested a review of the medical fee dispute involving services provided on April 26, 2024. The provider billed $28,824. The provider acknowledges that the carrier had already paid the provider the amount of $3,763. The provider is seeking additional payment of $11,598.70. The correct venue for the resolution of the medical fee dispute is with the Coventry Health Care Network.

On the merits, the provider is not entitled to any additional payment. The provider billed for CPT codes 99223, 26418, 26735, 11012, 26756, 13131, 11760, 29125 and 76000. We are attaching a copy of billing and reimbursement information for each of those CPT codes. As noted above, the provider has been paid all of the monies that the provider is entitled to."

Response Submitted by: Flahive, Ogden & Latson

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reasons

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

- 845 – No significant identifiable evaluation and management service has been documented.
- 243 – The charge for this procedure was adjusted in accordance with multiple surgical procedure rules and/or guidelines.
- 299 – This service is an integral part of total service performed ad does not warrant separate procedure charge.
- 906 – In accordance with clinical based coding edits (national correct coding initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- B12, 162, and 97 – No description provided on the EOBs.

Issues

1. Did the respondent submit documentation to the division that the requestor is participating in the Coventry Health Care network?
2. Are the reasons provided by the insurance company for denying the claim supported?
3. Does the multiple procedure payment reduction (MPPR) policy apply to the surgery services?
4. Is the requester entitled to additional reimbursement?

Findings

1. The requestor submitted this dispute seeking reimbursement in accordance with 28 TAC §133.307. The dispute concerns surgery services provided by the requestor on April 26, 2024.

   The insurance carrier states, "The correct venue for the resolution of the medical fee dispute is with the Coventry Health Care Network."

   The insurance carrier did not submit documentation to support that the healthcare provider was enrolled in the Coventry Health Care network. In fact, the carrier processed and paid several CPT codes **without** applying a network reduction, indicating no network status was verified or applied.

   The requestor seeks payment for CPT codes 99223, 11012, 13131, 29125, and 76000 with the denial reduction codes indicated above. The disputed services are therefore reviewed in accordance with 28 TAC §133.307 and §134.203.

2. This dispute concerns the nonpayment for surgical services provided on April 26, 2024. The requestor is seeking reimbursement for the following CPT codes: 99223, 11012, 13131, 29125, and 76000. Claims for CPT codes 26418, 26735, 26756, and 11760 were also submitted for the same date of service; however, these codes have already been reimbursed by the insurance company and are not part of this dispute.

   28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   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."

The CPT code descriptions for the disputed services are as follows:

- CPT code 99223-Initial hospital inpatient or observation care/day.
- CPT code11012-Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone.
- CPT code 13131-Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm.
- CPT code 29125-Application of short arm splint (forearm to hand); static.
- CPT code 76000-Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time.

The requestor appended the following modifiers:

- ET – Emergency Services
- 59 – Distinct procedural service.
- F8 – Right hand fourth digit
- F7 – Right hand third digit.
- F9 – Right hand fifth digit.
- RT – right side

Dr. Bailey billed the following CPT codes for the disputed date of service: 99223, 26418, 26735, 11012, 26756, 13131, 11760, 29125, and 76000.

To determine if any of these services have edit conflicts that could affect payment, the Division of Workers' Compensation (DWC) performed NCCI (National Correct Coding Initiative) edits. The DWC's findings are as follows:

- 99223 – According to Medicare guidelines, E/M code 99223 should not be billed without an appropriate modifier when submitted on the same day as a minor procedure or on the same day or day before a major procedure, both of which appear on the claim. Additionally, CPT 99223 is unbundled with codes 11012, 26418, 26735, 26756, and 11760. Since the requestor did not add a modifier to address this conflict, reimbursement is not recommended.
- 11012 – Per Medicare CCI guidelines, code 99223 has an unbundled relationship with code 11012. However, the requestor documented this service as billed appropriately. Therefore, reimbursement is recommended.
- 76000 – Describes a diagnostic procedure that requires a professional component modifier in POS 22. The requestor did not append a professional component modifier in POS 22 as a result; reimbursement is not recommended.
- 13131 – This code is unbundled with 26418, 26735, 26756, and 11760. Reimbursement is not recommended**.**
- 29125 – This code does not trigger any edits and is considered clean. Reimbursement is recommended.

Dr. Bailey billed the disputed procedure codes 76000, 29125, 13131 with modifier 59.

- Modifier -59 is described as a "Distinct Procedural Service" used to identify procedures/ services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

A review of the documentation included with the medical fee dispute request, does not support the use of modifier 59 for CPT codes 13131, and 76000. Because the denial reasons are supported the Division finds that the requestor is not entitled to reimbursement.

The division finds that the requestor is therefore entitled to reimbursement for CPT codes 29125 and 11012. These CPT codes are reviewed pursuant to 28 TAC §134.230.

3. 28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   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 (Field 34 or 35) 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 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 codes is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, you review the rank assigned by Medicare for each surgery code. Review of the Medicare MPFS documents the following rank for the surgery codes billed by the requestor:

   - CPT Code: 26418 is the highest valued procedure, reimbursement at 100%, previously paid by the insurance carrier.
   - CPT Codes: 29125 and 11012 reimbursement is at 50% for the second through the fifth highest valued procedure.

Per Medicare payment policy, "Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage."

The DWC finds that, "Base payment for each ranked procedure code on the lower of the billed amount: 100% of the fee schedule amount for the highest valued procedure; and 50% of the fee schedule amount for the second through the fifth highest valued procedure."

Under Medicare payment policies (per §134.203), MPPR applies when multiple surgeries are performed during the same session. The insurance carrier correctly paid the highest valued code (26418) at 100%. The additional surgical procedures (11012 and 29125) fall within the second-through-fifth range and are subject to a 50% payment adjustment.

4. The requester is entitled to 50% of the Medicare allowable amount for CPT codes 11012 and 29125.

28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

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

- Date of service in dispute: April 26, 2024
- The 2024 DWC Surgery Conversion Factor is 85.12
- The 2024B Medicare Conversion Factor is 33.2875
- A review of the medical bills finds that the disputed services were rendered in zip code 77027; the Medicare locality is "Houston."
- The Medicare Participating amount for CPT code 29125 at this locality is $42.13.
- Using the above formula, the DWC finds the MAR is $107.73.
- The respondent paid $0.00.
- The multiple procedure rule applies, status indicator 2. Reimbursement is recommended at 50% of the MAR for a recommended amount of $53.86.
- The Medicare Participating amount for CPT code 11012 at this locality is $434.63.
- Using the above formula, the DWC finds the MAR is $1,111.40 x 2 units = $2,222.80.
- The respondent paid $0.00.
- The multiple procedure rule applies, status indicator 2. Reimbursement is

recommended at 50% of the MAR for a recommended amount of $1,111.40.

The DWC determines that the requestor is entitled to an additional reimbursement of $1,165.26 for CPT codes 29125, and 11012. As a result, $1,165.26, is due.

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.

The DWC finds the requestor has established that additional reimbursement in the amount of $1,165.26 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. The respondent is ordered to remit $1,165.26, plus applicable accrued interest, to the requestor within 30 days of receiving this order, in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 20, 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, 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.