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**
AIU Insurance Co.

**MFDR Tracking Number**
M4-25-1807-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
April 7, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| January 6, 2025 | 2090[2] | $1,358.00 | $380.52 |

## Requestor's Position

"THE PERFORMED PROCEDURES WERE MEDICALLY INDICATED, PERFORMED FOR THE COMPENSABLE INJURY AND DO NOT HAVE ANY CONFLICTS WITH NCCI EDITS...THE OPERATIVE REPORT CLEARLY STIPULATES A SEPARATE INCISION."

**Amount in Dispute:** $1,358.00

## Respondent's Supplemental Position

The Austin carrier representative for AIU Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on April 15, 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 §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 §133.305 sets out general Medical Dispute Resolution guidelines.
3. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgical centers.

Adjustment Reasons

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

- TX435 - PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
- 236 - THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDUR/MODIFIER COMBINATION PROVIDED ON THE SAME DAY.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What Rule applies to the reimbursement of the service in dispute?
2. Is the insurance carrier's denial reason supported?
3. Is the requestor entitled to reimbursement for the disputed service?

Findings

1. This medical fee dispute involves professional charges for surgical services rendered on January 6, 2025, in a licensed ambulatory surgical center. Specifically, surgery procedure code 20902 was not allowed reimbursement and is the only procedure code in dispute.

   DWC finds that Rule 28 TAC §134.203(b)(1) applies to reimbursement of the services in dispute, stating, "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. Per a review of the explanation of benefits (EOB) documents submitted, the insurance carrier denied reimbursement for the disputed CPT code 20902-59 based on National Correct Coding Initiative (NCCI) edit conflicts.

   28 TAC §134.203(b)(1), which applies to the reimbursement of the disputed service, 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."

   On the disputed date of service, the requestor billed one unit each of CPT codes 27792-RT, 27829-59-RT and 20902-59. DWC completed NCCI edits and found that "Per Medicare CCI Guidelines, procedure code 20902 has an unbundle relationship with history procedure code 27829. Review documentation to determine if a modifier is appropriate." In its review of NCCI edits for the billed codes, DWC also found that "Per Medicare CCI Guidelines, procedure code 20902 has an unbundle relationship with history procedure code 27792. Review documentation to determine if a modifier is appropriate."

   The requestor appended the disputed procedure code, 20902, with modifier "59" indicating the procedure was distinct and independent from other procedures performed on the same day. A review of the medical record supports that the procedure represented by CPT code 20902 was a separate and distinct procedure, performed on a different site and via a separate incision from other procedures performed on the same date of service, January 6, 2025. DWC finds that the use of modifier "59" appended to CPT code 20902, on the disputed date of service, is supported by medical documentation and overrides the NCCI edit conflict appropriately.

   DWC finds that the insurance carrier's reason for denial based on NCCI edit conflict is not supported.

3. The requestor is seeking reimbursement in the amount of $1,358.00 for the procedure code 20902-59 rendered on January 6, 2025, in a licensed ambulatory surgical center. Because the insurance carrier's reason for denial is not supported, DWC finds that the requestor is entitled to reimbursement for procedure code 20902-59.

   On the disputed date of service, the requester billed one unit of procedure code 20902-59 in addition to other related surgical procedures. A review of the DWC060 Medical Fee Dispute Resolution (MFDR) request form finds that 20902 is the only procedure code in dispute. Therefore, only procedure code 20902 will be reviewed in this MFDR process.

   Procedure code 20902 is officially described as "Bone graft, any donor area; major or large" and refers to the procedure of harvesting a bone graft from any donor area, specifically for

major or large defects. The requestor appended the surgery procedure code with modifier "59" which indicates a distinct and separately identifiable service.

> Per Medicare Modifier 59 and X(EPSU) Fact Sheet, "Modifier 59 identifies procedures/services, other than E/M services and radiation treatment management, which 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)…
>
> Do not report modifier 59 or other NCCI-associated modifiers to bypass an edit unless documentation in the medical record supports its use."

A review of the submitted operative report finds the medical documentation supports that the service represented by CPT code 20902-59 was was performed as a distinct and separately identifiable procedure. The operative report documents that this procedure was performed at a different site and by a separate incision from other procedures performed in the same session. Therefore, DWC will adjudicate for the maximum allowable reimbursement (MAR) for CPT code 20902-59 rendered on January 6, 2025.

28 TAC §134.203(c) applies to the reimbursement of the service in dispute and 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."

Per Medicare payment policies, "…for procedure codes with an indicator status of '2' 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."

A review of the submitted medical report supports that multiple surgical procedures were performed on January 6, 2025, within the same surgical session, by the same healthcare provider. As a result, the multiple procedure payment adjustment will be applied when

calculating the MAR for the disputed procedure code 20902-59.

A review of the Medicare Physician Fee Schedule (MPFS) finds that of the three surgery codes billed on the disputed date, procedure code 20902 receives the lowest reimbursement, therefore, the Medicare Fee amount shall be adjusted to Fifty percent for procedure code 20902.

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

- The disputed service was rendered in zip code 77027, locality 18, "Houston."
- The Medicare participating amount for CPT code 20902 in January of 2025, rendered in a facility setting at this locality is $279.41.
- The multiple procedure adjustment applies at 50% of the Medicare fee amount; therefore, the applicable multiple procedure fee for CPT code 20902 on the disputed date of service is $139.71.
- The 2025 DWC Surgery Conversion Factor is 88.1.
- The Medicare Conversion Factor in 2025 is 32.3465.
- Using the above formula, DWC finds the MAR is $380.52 for CPT code 20902 on January 6, 2025, rendered in a facility setting in locality 18.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $380.52 is recommended for CPT code 20902 rendered on January 6, 2025, in a facility setting.

DWC finds that the requestor is entitled to reimbursement in the amount of $380.52 for the disputed surgery procedure code 20902-59 rendered on January 6, 2025, in a licensed ambulatory surgical facility.

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 $380.52.

## 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, AIU Insurance Co., must remit to the Requestor, Gulf Coast Orthopedics, $380.52 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

| | | |
|---|---|---|
| | | June 30, 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.