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

Requester Name
Occu-Health Surgery Center

Respondent Name
First Liberty Insurance Corp.

MFDR Tracking Number
M4-25-2644-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
June 23, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 15, 2025	55520	$29,167.00	$1,963.37

Requester's Position

"According to the Medicare National Correct Coding Initiative (NCCI) database:

- CPT 49650 (Column 1)
- CPT 55520 (Column 2)
- Modifier Indicator: 1 (Exception allowed)

"This means that CPT 55520 may be reimbursed separately if a modifier is appropriately appended and documentation supports distinct procedural service. In this case:

- Modifier -59 was used correctly to indicate that 55520 represents a separate and distinct procedure from the … The use of modifier -59 is fully supported by operative documentation."

Excerpt from Requester's Rebuttal letter: "Operative Report Supports a Separate and Distinct Procedure… There was a [redacted medical condition] that was present. This was reduced into the abdominal cavity… This reduction of a separate, identifiable [redacted medical condition] mass was not incidental to the [redacted medical condition] repair. It was a distinct lesion requiring specific surgical attention beyond the routine [redacted medical condition] repair, satisfying the NCCI's requirement for a 'separate lesion or injury'… The payer's rationale that both procedures occurred at the same anatomical location does not preclude modifier 59 usage.

CMS guidance (MLN Matters SE1418) affirms modifier 59 applies when distinct lesions are treated—even within the same region—when they represent separate pathologies… [redacted medical condition] are known to cause groin pain and may complicate [redacted medical condition] surgery. The excision/reduction of the [redacted medical condition] in this case was a medically necessary and deliberate intervention, not incidental."

Amount in Dispute: $29,167.00

Respondent's Position

"The bill has been reviewed, and no additional payment is due. This denial of 55520 is a separate procedure that was inclusive in another billed code is correct. Please see the attached showing that 55520 is inclusive in 49650. The NCCI (National Correct Coding Initiative) pair to pair edit can be overridden by a supported modifier 59. The modifier 59 appended to 55520 is not supported."

Response submitted by: Liberty Mutual Insurance

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

According to the most current explanation of benefits (EOB) submitted by the respondent, dated March 31, 2025, the insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 299 - THIS SERVICE IS AN INTEGRAL PART OF TOTAL SERVICE PERFORMED AND DOES NOT WARRANT SEPARATE PROCEDURE CHARGE.
- 876 - FEE SCHEDULE AMOUNT IS EQUAL TO THE CHARGE
- P12 - WORKERS' COMPENSATION STATE FEE SCHEDULE ADJ
- 983 - CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC SCHEDULE ALLOWANCE.
- 851 - THE ALLOWANCE WAS ADJUSTED IN ACCORDANCE WITH MULTIPLE PROCEDURE RULES AND/OR GUIDELINES.

Issues

1. As of the date of this review, what is the total amount of reimbursement that has been allowed for the services rendered on the disputed date, January 15, 2025?
2. What rule applies for determining the reimbursement for the disputed services?
3. Is the insurance carrier's reason for denial of CPT code 55520-59-LT supported?
4. Is the requester entitled to reimbursement for the disputed service billed under CPT code 55520-59-LT?

Findings

1. This medical fee dispute involves the reduced payment for surgical services rendered to an injured employee in a licensed ambulatory surgical center on January 15, 2025.

   A review of the submitted explanation of benefits (EOB) dated March 5, 2025, finds that the insurance carrier initially allowed reimbursement in the total amount of $8,713.14, for services rendered on January 15, 2025. This EOB allowed reimbursement in the amount of $0.00 for the disputed CPT code 55520-59-LT.

   Per a subsequent EOB dated April 11, 2025, the insurance carrier allowed additional reimbursement in the amount of $70.91, with procedure code 55520-59-LT still receiving $0.00 reimbursement.

   DWC finds that as of the date of this review, the requester has been reimbursed in the total amount of $8,784.05 plus interest for services rendered on January 15, 2025, with the CPT code in dispute, 55520-59-LT, receiving reimbursement in total amount of $0.00.

2. A review of the submitted documentation finds that this medical fee dispute involves non-payment for a surgical service billed under CPT code 55520-59-LT, rendered in a licensed ambulatory surgical center (ASC) on January 15, 20025.

   DWC finds that Rule 28 TAC §134.402 applies to the reimbursement of the services in dispute.

   DWC Rule 28 TAC §134.402 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, specifically Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers. Per section 30, beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor-related share. Furthermore, per Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers, section 40.5, when more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the procedures have the same HCPCS code. When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest

paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

DWC Rule 28 TAC §134.402 (f) states in pertinent part "the reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register…
(1) Reimbursement for non-device intensive procedures shall be:

> (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
> (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
>
> > (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
> > (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent."

A review of the submitted medical bills finds that the facility did not request separate reimbursement for surgical implantables in this case.

3. The requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $29,167.00 for surgical procedure code 55520-59-LT rendered on January 15, 2025.

   A review of the submitted medical bill finds that the requester billed for surgery services rendered on the disputed date under CPT codes 49591, 49650, and 55520-59-LT.

   A review of the submitted EOB documents finds that surgical procedure codes 49591and 49650-LT have previously been allowed reimbursement in the total amount of $8,784.05 as of the date of this review and these CPT codes are not in dispute. Per the submitted EOBs, the insurance carrier denied reimbursement for the disputed CPT code 55520-59-LT with a denial explanation asserting that the service of CPT code 55520-59-LT was an integral part of the total services performed on the same date, and that separate reimbursement is not warranted.

   DWC completed NCCI edits and found the following:

   > Procedure code 55520 has an unbundle relationship with procedure code 49650; review documentation to determine if a modifier is appropriate.

   The requester appended the disputed CPT code with modifier "59" on the medical bill. In its position statement the insurance carrier asserts that modifier "59", appended to CPT code 55520, is not supported by the medical documentation. The respondent states in the position statement that CPT code 55520 is inclusive in the service of CPT code 49650 and that modifier "59" is not supported because these two procedures were performed in the same anatomical site, as indicated by the LT (anatomical left) modifier.

   Medicare Modifier 59 Fact Sheet states in pertinent part "Under certain circumstances, it may

be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances… Appropriate Uses: … Separate lesion, or separate injury (or area in injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."

Further confirmation and additional guidance regarding the proper use of modifier "59" can be found at CMS article MLN1783722: Proper Use of Modifiers 59, XE, XP, XS & XU.

CPT code 55520 is described as "Excision of lesion of spermatic cord (separate procedure)."

CPT code 49650 is described as "Laparoscopy, surgical; repair initial inguinal hernia."

A review of the submitted operative report finds that a service distinct from CPT code 49560 was performed and documented, which supports the use of modifier "59" appended to CPT code 55520 on the submitted medical bill.

DWC finds that the use of modifier "59" appended to the disputed CPT code 55520 is supported. As a result, the insurance carrier's denial reason as stated on the EOB and in its position statement, is not supported.

4. The requester, a licensed ambulatory surgical center, is seeking reimbursement for the disputed procedure code 55520-59-LT, rendered on January 15, 2025. Because the insurance carrier's reason for denial is not supported, DWC finds that the requester is entitled to reimbursement. Calculation of the MAR in accordance with DWC Rule 28 TAC §134.402 is shown below.

   Procedure Code 55520 has a payment indicator of A2 indicating "a surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight." In accordance with DWC Rule 28 TAC §134.402 (f), reimbursement shall be based on the Medicare ASC facility reimbursement amount multiplied by 235 percent. Per the ASC Addendum AA for the applicable date of service, the Medicare facility reimbursement amount is $1,655.31.

   Per the ACS addendum AA for the applicable date of service, DWC finds that CPT code 55520 is subject to the Medicare multiple procedure payment reduction (MPPR) rule. A review of the Medicare Claims Processing Manual – Chapter 14, Section 40.5 – Payment for Multiple Procedures, finds that when more than one surgical procedure is performed in the same operative session, special payment rules apply. When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

   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

   DWC Rule 28 TAC 134.402 (f) (2) states in pertinent part "reimbursement for non-device

intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent." The following formula is used to calculate the MAR:

- The Medicare ASC reimbursement for code 55520 for applicable date of service is $1,655.31.
- The Medicare ASC reimbursement is divided by 2 = $827.655.
- This number multiplied by the CBSA index of 1.0189, for Houston-Pasadena-The Woodlands, TX region = $843.298.
- Add these two together, $827.655 + $843.298 = $1,670.953, which is the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT code 55520, multiply the geographically adjusted Medicare ASC reimbursement of $1,670.953 by the DWC payment adjustment factor of 235% = $3,926.739.
- Because this procedure was furnished in the same session as another primary procedure billed under CPT code 49650, the disputed CPT code 55520 is subject to MPPR discounting; therefore, the MAR is fifty percent of $3,926.739, or $1,963.37.
- The insurance carrier paid $0.00.
- Reimbursement is recommended in the amount of $1,963.37 for CPT code 55520-59-LT rendered on January 15, 2025.

DWC finds that the requester is entitled to reimbursement in the amount of $1,963.37 for CPT code 55520-59-LT rendered on January 15, 2025.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due in the amount of $1,963.37.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to reimbursement for disputed service. It is ordered that First Liberty Insurance Corp. must remit to Occu-Health Surgery Center, $1,963.37 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		August 8, 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.