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

General Information

Requester Name
Daniel Leeman, MD

Respondent Name
Liberty Mutual Insurance Corporation

MFDR Tracking Number
M4-25-2840-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
July 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 26, 2024	21335	$1,825.00	$0.00
September 26, 2024	30140	$358.19	$228.99
	Total	$2,183.19	$228.99

Requester's Position

"I am respectfully appealing against this denied claim for CPT 21335 and 30140 with the Operative Report attached. CPT 21335 was denied with reason code 275-the submitted report does not substantiate the service being billed. The operative report describes in detail the entire operation. CPT 21335 was billed because Dr. Leeman performed an open repair of a (redacted). CPT 30140 was denied as being included in another procedure. The operative report shows that Dr Leeman performed CPT 30140 for a distinctly different diagnosis. Modifier 59 was appended to CPT 30140 and identifies a distinct and separate procedure. I believe these CPT codes should be paid for with the information I am providing with this request."

Amount in Dispute: $2,183.19

Respondent's Position

"The denials on codes 21335 and 30140 are supported. Code 30140 is inclusive in 21335 per NCCI (National Correct Coding Initiative) pair to pair edits. The modifier 59 is not supported since the procedures occurred in the same anatomical area. Modifier 59: 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. Since all the procedures occurred in the same anatomical site modifier 59 is not supported. Code 21335: Open treatment of nasal fracture; with concomitant open treatment of fractured septum. Per the operative report attached to the dispute filed by the provider, it states that a closed reduction of the nasal fracture was done. On page two of the report, it states that a closed reduction was performed… This code, 21335, was denied since it is not documented on the report."

Response Submitted by: Liberty Mutual Insurance

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 MDR – General.
2. 28 TAC §133.307 Medical Fee Dispute Resolution.
3. 28 TAC §134.203 Medical Fee Guidelines for Professional Services.
4. 28 TAC §133.240 Medical Payments and Denials.

Denial Reasons

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

- 275 - The charge was disallowed as the submitted report does not substantiate the service being billed.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5917 – Pre-authorization was required but not requested for this service per DWC rule 134.600.
- U301 - This item has been reviewed on a previously submitted bill or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.

Issues

1. Did the insurance carrier provide adequate explanations for denial reason codes 16, 162, 197, and 18?
2. Are the insurance carrier's denials supported by applicable rules and documentation?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement in the amount of $2,183.19 for surgical services performed on September 26, 2024. A review of the Explanation of Benefits (EOBs) for the disputed CPT codes 21335 and 30140 indicates that the insurance carrier issued denials using reduction codes 275, 193, and 5917 U301, all of which included explanations.

   However, denial codes 16, 162, 197, and 18 lacked explanatory statements for the denial of the disputed services. In accordance with 28 TAC §133.240(f)(17)(H), a denial must include a reason for reduction if the adjustment code was listed under subparagraph (G) and applicable.

   As a result, the Division of Workers' Compensation (DWC) cannot determine the basis for the denials under codes 16, 162, 197, and 18. Therefore, the DWC will consider only the denial reasons associated with codes 275, 193, and 5917 U301.

2. The requester billed the following CPT codes with associated modifiers for the surgical procedure on September 26, 2024:

   - 30520 – Septoplasty or submucous resection (with/without cartilage grafting)
   - 21335-51-59 – Open treatment of nasal fracture with septal fracture
   - 31255-50-51-59 – Maxillectomy, without orbital exenteration
   - 30140-50-51-59 – Submucous resection of inferior turbinate
   - 31267-50-51-59 – Surgical endoscopy with removal of tissue from maxillary sinus
   - 31240-50-51-59 – Endoscopic resection of concha bullosa
   - 61782 – Stereotactic computer-assisted (navigational) procedure (cranial, extradural)
   - 77011 – CT guidance for stereotactic localization
   - 99080-73 – Work status report (division-specific code)

   Modifier Descriptions:

   - 50 – Bilateral procedure
   - 51 – Multiple procedures
   - 59 – Distinct procedural service
   - 73 – Division-specific work status report

The DWC applied CMS Medicare billing guidelines and completed a National Correct Coding Initiative (NCCI) edit review.

- CPT Code 21335:
  This code did not trigger any CCI edits and is considered "clean" as submitted. However, a review of the operative report lacks documentation of open treatment; only closed reduction is described. Therefore, the denial of this code is supported by the absence of sufficient documentation.
- CPT Code 30140:
  This code has an unbundling relationship with CPT code 21335, meaning that modifier 59 must be supported by documentation indicating a distinct procedural service.
  Upon review, the documentation demonstrated that the provider documented a distinct procedure (submucosal turbinate reduction.) The procedure was performed on different anatomical structures and for a different indication than the nasal fracture treatment, modifier 59 is appropriate in this case. The denial of CPT 30140 is not support; the requester is entitled to reimbursement for this code.

3. The DWC determines that the submitted medical documentation does not justify separate reimbursement for CPT code 21335. The insurance carrier's denials are supported by CMS Medicare billing and coding guidelines and 28 TAC §134.203. Therefore, the requester is not entitled to reimbursement for CPT code 21335.

   The requester, however, does support reimbursement for CPT code 30140. Reimbursement is determined under 28 TAC §134.203.

   Per 28 TAC §134.203(c)(1), to determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants must apply Medicare payment policies with minimal modifications. For service categories including Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery performed in an office setting, the established conversion factor is $53.68.

   The Medicare Claims Processing Manual, Chapter 12 – Physician/Nonphysician Practitioners indicates, that multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. Intraoperative services, incidental surgeries or components of surgeries will not be separately reimbursed.

   Reimbursement is based on the following guidelines for multiple surgical procedures:

   - 100% of the allowance for the highest valued procedure.
   - 50% of the allowance for the second through the fifth highest valued procedures.

   The regular multiple surgery rules, as referenced above, will be applied to the procedure codes below when billed for the same beneficiary on the same day, by the same physician.

The requester submitted billing for a series of medical procedure codes, primarily related to ENT (ear, nose, and throat) surgeries, along with some neurosurgical and radiologic procedures. The CPT code recommended for payment is not classified as an endoscopic procedure. Although the requester billed for some endoscopy procedures, those procedures are not in dispute, as such the special rules for multiple endoscopic procedures do not apply to the CPT code recommended for payment.

The CMS multiple surgery procedure payment reduction applies to CPT code 30140, and the highest-valued procedure is undisputed and has been previously reimbursed by the insurance carrier. In accordance with the multiple surgery payment reduction policy, CPT code 30140 should be reimbursed at 50% of the fee guideline.

The MAR is calculated using the formula:
(DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment = Maximum Allowable Reimbursement (MAR).

- Date of service(s) in dispute: September 26, 2024
- Service Location: ZIP Code 78723 (Austin, Locality 31) Carrier: 4412
- The DWC 2024 Surgery Conversion Factor is 85.12
- The 2024B Medicare Conversion Factor is 33.2875
- Services performed in a facility setting
- Participating Provider Rate: CPT code 30140 = $179.10 / 50% multiple procedure rule applies = $89.55
- Using the formula to determine the MAR, the fee schedule reimbursement is $228.99
- Amount Billed: $$1,725.00
- Amount Paid: $0.00
- Amount Sought: $358.19
- Amount Recommended: $228.99

The DWC finds that the requester is entitled to reimbursement for the disputed services. As a result, $228.99 is due.

Conclusion

While not all the evidence submitted was discussed in detail, it was fully considered in reaching this decision.

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

The services billed under CPT code 21335 were not adequately supported by medical documentation, and the insurance carrier's denials reason for non-payment of this code is supported.

The services billed under CPT code 30140 were supported and the requester is entitled to reimbursement in the amount of $228.99.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requester $228.99 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 6, 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 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 512-804-4812.