



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requester Name**

Gulf Coast Orthopedic and Hand Surgery

**Respondent Name**

Zurich American Insurance Company

**MFDR Tracking Number**

M4-26-0134-01

**Insurance Carrier's Austin Representative**

BOX 19 Flahive Ogden & Latson

**DWC Date Received**

September 12, 2025

## Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 17, 2025	11012	\$3,321.00	\$0.00
January 17, 2025	13132	\$2,396.00	\$0.00
January 17, 2025	20525	\$2,306.00	\$347.36
January 17, 2025	64702	\$2,538.00	\$721.41
<b>Total</b>		<b>\$10,561.00</b>	<b>\$1,068.77</b>

## Requester's Position

"Despite clear operative documentation, CPT codes 11012, 13132, 20525, and 64702 were denied ...

"Each of the disputed CPT codes represents a separate, identifiable procedure documented in the operative report:

- \*\*CPT 13132 (Complex repair) vs CPT 26746 (Open fracture fixation) and CPT 11012 (Debridement of open fracture)\*\*
  - CPT 13132 is defined by AMA as a complex layered closure requiring undermining, exposure of tendon/nerve, and closure of structures not included in bone work.

- CPT 11012 only covers irrigation and debridement of the open fracture or dislocation, limited to skin/subq/bone preparation. It does not include layered undermining, tendon/nerve coverage, and closure of a 6.4 cm wound.
- CPT 26746 addresses reduction and stabilization of the phalanx fracture not layered closure of exposed tendon and nerve structures.
- Therefore, CPT 13132 is independent: closure was a distinct, extensive task requiring undermining and layered repair beyond fracture fixation or debridement.
- 2. **\*\*CPT 64702 (Neurolysis of digital nerve) vs CPT 26020 (Drainage of tendon sheath)\*\***
  - CPT 64702 involves appreciable dissection of digital nerves, freeing them from hematoma and debris. AMA CPT guidance clarifies that simple exploration is included, but formal neurolysis requiring appreciable dissection qualifies as separately reportable.
  - CPT 26020 is limited to incision/drainage of the tendon sheath. The nerve lies outside the sheath and is not part of the tenosynovitis drainage.
  - Therefore, CPT 64702 is independent: the neurolysis was medically necessary and distinct from tendon sheath drainage.
- 3. **\*\*CPT 20525 (Foreign body removal, tendon sheath) vs CPT 11012 (Debridement)\*\***
  - CPT 20525 is for removal of a foreign body specifically embedded within the tendon sheath.
  - CPT 11012 addresses debridement of devitalized tissue in the open fracture but does not include targeted excision of a foreign body from the flexor sheath.
  - Therefore, CPT 20525 is independent, as foreign body removal required separate surgical work not bundled into fracture debridement.

**\*\*NCCI Policy & Edit Review\*\***

- Review of NCCI edit tables confirms there are no bundling edits between CPT 11012, 13132, 20525, and 64702 when appropriately documented.
- AMA CPT guidance distinguishes complex repair, foreign body removal, and neurolysis as separately reportable when appreciable dissection or distinct steps are performed.
- The carrier's denials as 'inclusive' are contrary to both NCCI and AMA CPT guidelines ...

"Per 28 TAC §134.203, reimbursement shall be made in accordance with the Division's fee guidelines for each CPT code billed when medically necessary and performed ...

"These services were emergent, necessary, distinct, supported by operative documentation, and free from NCCI conflicts."

**Amount In Dispute:** \$10,561.00

### **Respondent's Position**

"Our bill audit company has determined additional monies are owed in the amount of \$417.10.

**Response Submitted By:** Gallagher Bassett

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

### Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 90121 (59) – Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
2. 90223 (P12) – Workers' compensation jurisdictional fee schedule adjustment.
3. 90950 – This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous payment.
4. 31029 – Per CPT code description, debridement code is only allowed for open fractures or dislocations. Service included in another code billed on the same day.
5. 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
6. 90202 (B13) – Previously paid. Payment for this claim/service may have been provided in a previous payment.
7. 247 – A payment or denial has already been recommended for this service.

### Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Is the insurance carrier's reduction based on bundling supported?
4. Is the requester entitled to additional reimbursement?

### Findings

1. The requester is seeking reimbursement for procedure codes 11012, 13132, 20525, and 64702, billed in conjunction with paid procedure codes 26746 and 26020. Procedure codes 13132, 20525, 64702, 26746, and 26020 were billed with modifier "59." The insurance carrier's denial of payment for the disputed services included denial code 59, stating, "Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules."

Procedure code 11012 is defined as, "Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin,

subcutaneous tissue, muscle fascia, muscle, and bone.”

Procedure code 13132 is defined as “Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm.”

Procedure code 20525 is defined as “Removal of foreign body in muscle or tendon sheath; deep or complicated.”

Procedure code 64702 is defined as “Neuroplasty; digital, 1 or both, same digit.”

These are the services considered for reimbursement in this dispute.

Procedure code 26746 is defined as “Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each.”

Procedure code 26020 is defined as “Drainage of tendon sheath, digit and/or palm, each.”

These codes are not considered in this dispute except for how they affect reimbursement of the disputed codes.

2. The procedure codes in question are professional services subject to the fee guidelines found in 28 TAC Section 134.203, which states, in relevant part,
  - (b) 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 ... [emphasis added].
  - (c) To determine the 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 ...
    - (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 ...

Modifier F1 is defined as "Left hand, second digit."

Modifier 59 is defined as a distinct procedural service. Per Medicare [NCCI Manual](#), Chapter 1, E states:

"Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-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. 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** (emphasis added). However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

3. DWC finds that a CCI edit exists for disputed code 11012 and paid code 26020. A modifier may be allowed to override this conflict. This code was billed with modifier F1. This modifier does not override the conflict. The insurance carrier's denial of payment for this service is supported.

DWC finds that a CCI edit exists for disputed code 13132 and paid code 26020. A modifier is allowed to override this conflict. DWC finds that the submitted documentation does not support the use of modifier 59 to override this conflict. The insurance carrier's denial of payment for this code is supported.

DWC finds that no CCI edit exists between disputed code 20525 and any paid codes. The insurance carrier's denial of payment for this code is not supported.

DWC finds that a CCI edit exists for disputed code 64702 and paid code 26746. A modifier is allowed to override this conflict. DWC finds that the documentation supports separate incisions for these procedures. Modifier 59 is supported in this case. The insurance carrier's denial of payment for this service is not supported.

4. Because the insurance carrier's denial for procedure codes 11012 and 13132 were supported, the requester is not entitled to reimbursement for these codes. The insurance carrier's denial of payment for procedure codes 20525 and 64702 was not supported; therefore, the requester is entitled to reimbursement for these services.

Procedure codes 20525 and 64702 have a multiple procedure status of 2. Primary paid procedure code 26746 also has a multiple procedure status code of 2. Status code 2 indicates that "Standard payment adjustment rules for multiple procedures apply. If you report the procedure on the same day as another procedure with an indicator of 1, 2, or 3, MACs rank the procedures by fee schedule amount and apply the reduction to this code (100%, 50%, 50%, 50%, 50%, and by report)." MACs base payment on the lower of the actual charge and the fee schedule amount reduced by the correct percentage.

To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

- The DWC surgery conversion factor for professional services performed in a facility in 2025 is 88.10.
- The Medicare conversion factor for 2025 is 32.3465.
- Per the submitted medical bills, the service was rendered in zip code 77027 which is in Medicare locality 0441218.

The Medicare participating amount for CPT code 20525 is \$255.07. The maximum allowable reimbursement is calculated as follows:  $(88.10/32.3465) \times \$255.07 = \$694.72$ . The multiple procedure discounted amount is \$347.36. This amount is recommended.

The Medicare participating amount for CPT code 64702 is \$529.74. The maximum allowable reimbursement is calculated as follows:  $(88.10/32.3465) \times \$529.74 = \$1,442.82$ . The multiple procedure discounted amount is \$721.41. This amount is recommended.

DWC finds that the total allowable amount for the services in dispute is \$1,068.77. This amount is recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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.

### **Order**

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Zurich American Insurance Company must remit to Gulf Coast Orthopedic and Hand Surgery \$1,068.77 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
March 20, 2026

Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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](http://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 800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto: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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).