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
Liberty Mutual Fire Insurance Co.

MFDR Tracking Number
M4-26-0147-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
September 15, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2024	11012	$7,187.00	$0.00
December 5, 2024	64702	$13,988.00	$1,056.13
December 5, 2024	13132	$2,187.00	$383.27
December 5, 2024	76000	$2,471.00	$30.98
	Total	$25,833.00	$1,470.38

Requester's Position

"Liberty Mutual denied CPT codes 11012, 64702, 13132, and 76000 using adjustment codes 162 and 243. While 243 is defined as a 'bundled' denial, no definition for code 162 was provided on the EOB, in violation of 28 TAC §133.240(k), which requires carriers to clearly state the reason for reduction or denial.

"Even if 'bundling' is asserted, both NCCI edits, and AMA CPT guidance confirm these services are distinct and separately reportable."

Requester's Supplemental Position per correspondence with DWC dated September 29, 2025:

"While the carrier conceded additional reimbursement for CPT 11012, it continues to improperly deny CPT 64702, CPT 13132, and CPT 76000."

Amount in Dispute: $25,833.00

Respondent's Supplemental Position

"The carrier has determined that additional payment is warranted for CPT code 11012… Based on the documentation provided and NCCI guidance, the carrier finds it reasonable to allow separate reimbursement for CPT 11012, The carrier finds an additional payment of $1361.25 is due… CPT 13132 is considered inclusive and not separately reimbursable, and the denial is upheld… The carrier considers fluoroscopy an integral component of 26735… Therefore, CPT 76000 is considered inclusive to CPT 26735 and is not payable as a distinct service… CPT 64702 is considered included in the primary procedure (26735) and is not eligible for separate reimbursement, even with modifier 59. The denial is upheld based on NCCI policy and operative documentation."

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.
4. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Adjustment Reasons

- 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.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 983 – CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC SCHEDULE ALLOWANCE.
- 851 – ALLOWANCE WAS ADJUSTED IN ACCORDANCE WITH MULTIPLE PROCEDURE RULES AND/OR GUIDELINES.
- P12 - WORKERS COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 162, P13 – NOT DEFINED ON EXPLANATION OF BENEFITS (EOB) SUBMITTED.

Issues

1. As of the date of this review, what reimbursements have been allowed for the services in dispute?
2. What rule applies for determining the reimbursement for the disputed services?
3. Do the disputed services contain National Correct Coding Initiative (NCCI) edit conflicts that could have an impact on reimbursement?
4. Is the requester entitled to additional reimbursement for CPT code 11012?
5. Is the requester entitled to reimbursement for the disputed service billed under CPT code 64702-59-F1-ET?
6. Is the requester entitled to reimbursement for the disputed service billed under CPT code 13132-59-F1-ET?
7. Is the requester entitled to reimbursement for the disputed service billed under CPT code 76000-59-ET?
8. What is the total amount of additional reimbursement due to the requester for the services rendered on the disputed date of service?

Findings

1. This medical fee dispute involves the reduced or non-payment for surgical services rendered to an injured employee in a licensed ambulatory surgical center on December 5, 2024.

   A review of the submitted explanation of benefits (EOB), finds that the insurance carrier initially and upon reconsideration, allowed reimbursement in the total amount of $4,026.89 which included allowances for CPT code 26735-F1-ET in the amount of $3,573.69 and for CPT code C9290 in the amount of $453.89.

   A review of the submitted documentation finds an EOB dated September 24, 2025, allowing additional reimbursement of the disputed procedure code 11012-F1-ET in the amount of $1,361.25. The insurance carrier maintained its denial of payment for all other procedure codes in dispute.

   DWC finds that as of the date of this review, the requester has been reimbursed in the total amount of $5,388.14 plus interest for the date of service in dispute.

2. A review of the submitted documentation finds that this medical fee dispute involves surgical services rendered in a licensed ambulatory surgical center on November 11, 2024.

   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, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. 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.

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 implants in this case.

3. A review of the submitted medical bill finds that on the disputed date of service the requester billed for the following procedure codes: **11012-F1-ET**, 26735-F1-ET, **64702-59-F1-ET**, **13132-59-F1-ET**, **76000-59-26-ET**, and C9290. (disputed codes in bold font)

   DWC completed NCCI edits and found the following edit conflicts:

   - Procedure code 64702 has an unbundle relationship with history procedure code 26735; review documentation to determine if a modifier is appropriate.
   - Procedure code 11012 has an unbundle relationship with history procedure code 13132; review documentation to determine if a modifier is appropriate.
   - Procedure code 13132 has an unbundle relationship with history procedure code 26735; review documentation to determine if a modifier is appropriate.
   - No other procedure code combinations on the medical bill were found to have NCCI edit conflicts.
   - According to NCCI Procedure-to-Procedure Lookup site, all of the CPT code combinations above have a modifier policy indicator of "1" indicating that the use of a modifier is allowed to override NCCI conflicts when supported by documentation.

   CPT code 64702 is described as "Neuroplasty; digital, 1 or both, same digit… specifically targeting the digital nerves of one or both fingers or toes… involves the surgical treatment of nerve compression in the fingers or toes."

CPT code 11012 is described as "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."

Regarding CPT code 11012, DWC notes that Medicare LCD reference Article - Billing and Coding: Wound Care (A53001) states in pertinent part, "…debridement of tissue at the site of an open fracture or dislocation may be reported separately with CPT codes 11010-11012." This disputed code has previously received reimbursement at a reduced rate. DWC will review the reimbursement of CPT code 11012 for additional reimbursement due.

CPT code 13132 is described as "Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm." (*This procedure is necessary when the wound is deeper, jagged, or contains embedded debris, requiring a more intricate approach than a standard layered closure. The provider may need to perform additional tasks such as scar revision, extensive undermining of tissues, and the use of stents or retention sutures to ensure proper healing and anatomical alignment.)*

CPT code 76000 is described as "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time… The primary purpose of this code is to document the time spent by the healthcare professional in performing fluoroscopy as a standalone service, separate from other procedures that may also involve imaging guidance."

DWC does not find NCCI edit conflicts for the billing of CPT code 76000 with any of the other codes billed on the disputed date of service. A review of the submitted operative report supports the use of fluoroscopy as defined above during the procedure in question. Medical documentation submitted indicates that no other imaging guidance was utilized during the procedure. Therefore, DWC finds that the requester is entitled to reimbursement for CPT code 76000 rendered on December 5, 2025.

The requester appended disputed CPT codes 64702, 13132 and 76000 with modifier "59" 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 "ET" was also appended to indicate an emergency procedure.

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." 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.

DWC finds that the submitted operative report supports the use of modifier "59" as appended to the disputed CPT codes on the submitted medical bill.

4. According to the submitted DWC060 Medical Fee Dispute Resolution Request (MFDR) form,

the requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $7,187.00 for CPT code 11012 rendered on December 5, 2024. As indicated in finding number one, the insurance carrier paid $1,361.25 after the request for this MFDR. Therefore, DWC finds that the requester seeks additional reimbursement in the amount of $5,825.75 for CPT code 11012 as of the date of this review.

Procedure Code 11012 has a payment indicator of A2 indicating that payment is based on OPPS relative payment weight. Per the ACS addendum AA for the applicable date of service, DWC finds that CPT code 11012 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 11012 on the applicable date of service is $1,157.01.
- The Medicare ASC reimbursement is divided by 2 = $578.505.
- This number multiplied by the CBSA index of 1.0026, for Houston-The Woodlands-Sugar Land, TX region = $580.009.
- Add these two together = $1,158.514, which is the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT 11012, multiply the geographically adjusted Medicare ASC rate of $1,158.514 by the DWC payment adjustment factor of 235% = $2,722.508.
- Because this procedure was furnished in the same session as another primary procedure, CPT code 11012 is subject to MPPR discounting; therefore, the MAR is fifty percent of $2,722.508, or $1,361.254.
- DWC finds that the MAR for CPT code 11012 rendered on December 5, 2024, is $1,361.25.
- The insurance carrier allowed $1,361.25.

- Additional reimbursement is not recommended.

5. According to the submitted DWC060 Medical Fee Dispute Resolution Request (MFDR) form, the requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $13,988.00 for CPT code 64702-59-F1-ET rendered on December 5, 2024. Because the submitted operative report supports that the neurolysis service represented by CPT code 64702 was rendered as a distinct surgical service from other services rendered on the same date, DWC finds that the requester is entitled to reimbursement for this procedure code.

   Procedure Code 64702 has a payment indicator of A2 indicating that payment is based on OPPS relative payment weight. Per the ACS addendum AA for the applicable date of service, DWC finds that CPT code 64702 is subject to the Medicare multiple procedure payment reduction (MPPR) rule, in the same manner as indicated in finding number four.

   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 64702 on the applicable date of service is $897.67.
   - The Medicare ASC reimbursement is divided by 2 = $448.835.
   - This number multiplied by the CBSA index of 1.0026, for Houston-The Woodlands-Sugar Land, TX region = $ 450.002.
   - Add these two together = $898.837, which is the geographically adjusted Medicare ASC rate.
   - To determine the MAR for CPT 64702, multiply the geographically adjusted Medicare ASC rate of $898.837 by the DWC payment adjustment factor of 235% = $2,112.267.
   - Because this procedure was furnished in the same session as another primary procedure, CPT code 64702 is subject to MPPR discounting; therefore, the MAR is fifty percent of $2,112.267, or $1,056.134.
   - DWC finds that the MAR for CPT code 64702 rendered on December 5, 2024, is $1,056.13.
   - The insurance carrier paid $0.00.
   - Reimbursement in the amount of $1,056.13 is recommended for CPT code 64702 rendered on December 5, 2024.

6. According to the submitted DWC060 Medical Fee Dispute Resolution Request (MFDR) form, the requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $2,187.00 for CPT code 13132-59-F1-ET rendered on December 5, 2024. Because the submitted operative report supports that the service represented by CPT code 13132 met the criteria as a necessary and distinct surgical service, DWC finds that the requester is entitled to reimbursement for this procedure code.

   Procedure Code 13132 has a payment indicator of A2 indicating that payment is based on

OPPS relative payment weight. Per the ACS addendum AA for the applicable date of service, DWC finds that CPT code 13132 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 13132 on the applicable date of service is $325.76.
- The Medicare ASC reimbursement is divided by 2 = $162.88.
- This number multiplied by the CBSA index of 1.0026, for Houston-The Woodlands-Sugar Land, TX region = $163.303.
- Add these two together = $326.183, which is the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT 13132, multiply the geographically adjusted Medicare ASC rate of $326.183 by the DWC payment adjustment factor of 235% = $766.53.
- Because this procedure was furnished in the same session as another primary procedure, CPT code 13132 is subject to MPPR discounting; therefore, the MAR is fifty percent of $766.53, or $383.27.
- DWC finds that the MAR for CPT code 13132-59-ET rendered on November 11, 2024, is $383.27.
- The insurance carrier allowed $0.00.
- Reimbursement in the amount of $383.27 is recommended for CPT code 13132-59-F1-ET rendered on December 5, 2024.

7. According to the submitted DWC060 Medical Fee Dispute Resolution Request (MFDR) form, the requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $2,471.00 for CPT code 76000-59-26-ET rendered on December 5, 2024. For reasons indicated in finding number three above, DWC finds that the requester is entitled to

reimbursement for CPT code 76000-59-26-ET.

Procedure Code 76000 has an ASC payment indicator of Z3 indicating a "Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on Medicare Physician Fee Schedule (MPFS) non-facility PE RVUs." Per the MPFS for the applicable date of service, DWC finds that the Medicare non-facility fee for CPT code 76000-26 is $15.21.

DWC Rule 28 TAC §134.402(h) states, for medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

DWC Rule 28 TAC §134.203(c)(1) 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. 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 the conversion factor applicable to the disputed date of service.

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

- The disputed date of service is December 5, 2024.
- The disputed service was rendered in zip code 77027, locality 18, "Houston."
- The Medicare participating amount for CPT code 76000 on the disputed date of service at this locality is $15.21.
- The 2024 DWC Conversion Factor is 67.81
- The 2024 Medicare Conversion Factor on the applicable date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $30.98 for CPT code 76000 on the disputed date of service.
- The insurance carrier paid $0.00.
- Reimbursement is recommended in the amount of $30.98 for CPT code 76000 rendered on December 5, 2024.

8. The requester is seeking additional reimbursement in the total amount of $25,833.00 for services rendered in a licensed ambulatory surgical center on December 5, 2024.

   Per calculations demonstrated in finding numbers four, five, six and seven above, DWC finds that the requester is entitled to additional reimbursement in the total amount of $1,470.38 for the services in dispute rendered on December 5, 2024.

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 total amount of $1,470.38.

ORDER

Under Texas Labor Code §§413.031, the DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Liberty Mutual Fire Insurance Co. must remit to Occu-Health Surgery Center, $1,470.38 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 15, 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.