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

General Information

Requester Name
Jason Bailey, M.D., PA

Respondent Name
Ace American Insurance Co.

MFDR Tracking Number
M4-26-0408-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2025	40652	$4,430.88	$0.00
March 22, 2025	20103	$4,798.76	$446.21
March 22, 2025	64400	$967.64	$0.00
	Total:	$10,197.28	$446.21

Requester's Position

"Our claim was processed and paid a partial payment of $3,438.97 on 5/29/25 and 7/31/25. CPT codes 40652, 20103, 64400 are denying and not being paid. Failure to perform the medically necessary EMERGENT surgery could have resulted in placing the patient's health in serious jeopardy or serious impairment to bodily functions or even serious dysfunction of a bodily organ."

Amount in Dispute: $10,197.28

Respondent's Supplemental Position

"Corvel's nurse reviewer determined that the code billed on line 2, 40652, was incorrect for the service rendered… Additionally, CPT code 20103 has been identified as a separate procedure and is not separately payable when billed with other payable services… CPT code 64400, although submitted on a separate bill, bundles into CPT code 11043 which was paid under … Per CCE, a modifier is not allowed to override the CCI edit… It appears the Respondent is indicating that

because the services were performed as emergency care that payment is due for all codes as billed. However, that is incorrect. The fact that the services were emergent only negates the preauthorization requirement. All other rules apply and documentation must always support services billed."

Response submitted by: Corvel

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 §134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

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

- B12 – Svcs not documented in patient medical records.
- 59 – Allowance based on Multiple Surgery Guidelines.
- ET – Emergency Services
- 97 & R38 – Included in another billed procedure.
- W3 – Appeal/Reconsideration
- Explanation Comment: Decision maintained; CPT 40652 requires a through and through laceration. Documentation states the medial wound only penetrated the muscle and not the mucosa. There is a more appropriate CPT code for the laceration repair performed.

Issues

1. What Rule applies to the reimbursement of the services in dispute?
2. Do the disputed services contain National Correct Coding Initiative (NCCI) edit conflicts that may affect reimbursement?
3. Is the insurance carrier's denial reason of CPT code 40652 supported?
4. Is the insurance carrier's denial reason of CPT code 20103 supported?

5. Is the insurance carrier's denial reason of CPT code 64400 supported?

6. Is the requester entitled to reimbursement for the disputed services?

Findings

1. This medical fee dispute involves professional charges for surgical services rendered in a facility setting on March 22, 2025. Specifically, procedure codes 40652, 20103, and 64400 were not allowed reimbursement and are in dispute due to non-payment.

   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. DWC completed National Correct Coding Initiative (NCCI) edits to determine if edit conflicts may affect reimbursement.

   On the disputed date of service, the requester billed the CPT Codes noted below. The following was found, (disputed CPT codes are in bold font):

   30620 – No edit conflicts found

   20103 – No edit conflicts found

   40652 – No edit conflicts found

   99223-25-57 – No edit conflicts found

   40654-59 - No edit conflicts found

   11043-59 - No edit conflicts found

   12011-59 - No edit conflicts found

   64400 - Has an unbundle relationship with history procedure codes 30620, 40654, 20103, 40652, 12011, and 11043. Review documentation to determine if a modifier is appropriate.

3. Per a review of the explanation of benefits (EOB) documents submitted, the insurance carrier denied reimbursement for the disputed CPT code 40652 based on reason code B12 "Svcs not documented in patient medical record" with a comment stating in pertinent part, "There is a more appropriate CPT code for the laceration repair performed."

   Procedure code 40652 is described as "Repair lip laceration, full thickness; up to half vertical height." A full thickness lip laceration includes all layers of the lip including skin, muscle and oral mucosa.

   Per a review of the operative report submitted, DWC finds that procedure code 40652 is not

supported in the medical record as defined.

DWC finds that the insurance carrier's reason for denial of disputed CPT code 40652, is supported. As a result, reimbursement for disputed CPT code 40652 is not recommended in this case.

4. Per a review of the explanation of benefits (EOB) documents submitted, the insurance carrier asserts that it denied reimbursement for the disputed CPT code 20103 because the service is included in another billed procedure on the same date.

   Procedure code 20103 is described as "a medical procedural code under the range - Wound Exploration-Trauma (eg, Penetrating Gunshot, Stab Wound) Procedures on the Musculoskeletal System."

   A review of the submitted operative report finds that the documentation supports the service represented by CPT code 20103 was performed as a distinct and separately identifiable procedure. DWC finds no NCCI edit conflicts exist in the billing of CPT code 20103 as billed on the disputed date of service.

   DWC concludes that the insurance carrier's reason for denial of CPT code 20103 is not supported. Therefore, this code will be reviewed and adjudicated for the maximum allowable reimbursement (MAR).

5. Per a review of the explanation of benefits (EOB) documents submitted, the insurance carrier denied reimbursement for the disputed CPT code 64400 based on NCCI conflicts.

   As demonstrated in finding number two, DWC found CPT code 64400 to have NCCI edit conflicts with procedure codes 30620, 40654, 20103, 40652, 12011, and 11043 billed on the same date of service. The requester did not append a modifier which might override the NCCI edit conflicts.

   DWC finds that the insurance carrier's reason for denial of CPT code 64400 is supported. Therefore, reimbursement is not recommended for this disputed procedure code.

6. The requester is seeking reimbursement in the amount of $10,197.28 for disputed unpaid CPT codes 40625, 20103 and 64400.

   In accordance with the previous findings of this medical fee dispute resolution (MFDR) review, the only disputed procedure code eligible to be adjudicated for the MAR amount is CPT code 20103.

   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 the disputed date of service, March 22, 2025, within the same surgical session, by the same healthcare provider.

After a review of the Medicare Physician Fee Schedule (MPFS) DWC finds that CPT code 20103 has a multiple surgery status indicator of "2". According to the EOB submitted, the primary surgical code has previously received reimbursement at 100 percent of the MAR and is not in dispute, therefore, procedure code 20103 shall be adjusted to fifty percent of the Medicare Fee amount.

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 77304, locality 99, "Rest of Texas"
- The Medicare participating amount for CPT code 20103 in 2025, rendered in a facility setting at this locality is $327.66.
- The multiple procedure adjustment applies at 50% of the Medicare fee amount; therefore, the applicable multiple procedure fee for CPT code 20103 on the disputed date of service is $163.83.
- 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 $446.21 for CPT code 20103 on March 22, 2025, rendered in a facility setting in locality 99.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $446.21 is recommended for CPT code 20103 rendered on March 22, 2025, in a facility setting.

DWC finds that the requester is entitled to reimbursement in the amount of $446.21 for the disputed surgery procedure code 20103 rendered on March 22, 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 reimbursement is due in the amount of $446.21.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed service. It is ordered that the Respondent, Ace American Insurance Co., must remit to the Requester, Jason R. Bailey, M.D., $446.21 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 19, 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.