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

General Information

Requestor Name
Occu-Health Surgery Center

Respondent Name
Sompo America Insurance Co.

MFDR Tracking Number
M4-26-0432-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
October 14, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2025	11012	$7,187.00	$3,104.07

Requestor's Position

"NCCI Policy Manual 2025, Chapter III allows reporting of 11012 and 26236 together when documentation shows independent, medically necessary steps, as it does here… ICD-10 S62.637B (diagnosis description) directly supports the use of 11012… Pursuant to 28 TAC §133.307(c)(2)(N), the requestor maintains that payment for CPT 11012 was improperly denied. The documentation demonstrates the service was medically necessary, accurately coded, and distinct from both 26236 and 14040. The carrier's reduction contradicts CPT Assistant guidance (Dec 2021) and Texas Workers' Compensation medical-billing standards, which require reimbursement for separately identifiable debridement at … sites."

Amount in Dispute: $7,187.00

Respondent's Position

There were multiple bills filed by the surgeon and the facility for services provided on August 21, 2025. The provider is currently seeking reimbursement for one of four CPT codes billed on August 21, 2025. The CPT code is 11012 with modifiers of F4 and ET… No reimbursement was recommended for CPT code 11012… The payment of the provider's medical bill is consistent with the Medical Fee Guidelines. The provider is not entitled to any reimbursement."

Response submitted by: Flahive, Ogden & Latson

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 §134.402 sets out the fee guidelines for ambulatory surgical centers.

Adjustment Reasons

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

- 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.
- 0663 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON THE STATE GUIDELINES.
- P12 & 90223 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 983 – CHARGE FOR THIS PROCEDURE EXCEEDS MEDICARE ASC FEE SCHEDULE ALLOWANCE.
- 193 & 90563 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 - Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or carrier decision.

Issues

1. What rules apply to the services rendered in this medical fee dispute?
2. Is the insurance carrier's reason for reimbursement denial of CPT code 11012 supported?
3. What is the total maximum allowable reimbursement (MAR) amount for services rendered on the disputed date, August 21, 2025?
4. Is the requester entitled to additional reimbursement?

Findings

1. A review of the submitted documentation finds that this medical fee dispute involves surgical services rendered in a licensed ambulatory surgical center (ASC) on August 21, 2025.

   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.

2. On the disputed date of service, the requester billed CPT codes 14040-F4-ET, 11012-F4-ET, 26236-F4-ET, 11760-F4-ET.

   A review of the submitted explanation of benefits (EOB) finds that the insurance carrier reimbursed the requester for three of the CPT codes billed but denied payment for CPT code 11012 billed on the same date of service. Reimbursement was denied for CPT code 11012 based on the CPT code is only allowed in the presence of an open fracture and that the service of CPT code 11012 is included in another CPT code billed on the same day.

   DWC ran National Correct Coding Initiative (NCCI) edit checks for the four codes billed together on the disputed date of service and found no conflicts exist.

   Medicare 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." A review of the submitted medical bill and operative report

finds that the service of procedure code 11012 was performed as a separate and distinct service in the presence of an open fracture on the disputed date of service.

DWC finds that the insurance carrier's reason for denial of the disputed CPT code 11012 is not supported.

3. The requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $7,187.00 for CPT code 11012 rendered on August 21, 2025.

   Because the insurance carrier's reason for denial of procedure code 11012 rendered on August 21, 2025, is not supported, DWC finds that the requester is entitled to reimbursement in accordance with the applicable Rule 28 TAC §134.402.

   Per the ASC addendum AA for the applicable date of service, DWC finds that all four procedure codes billed on August 21, 2025, are subject to the Medicare multiple procedure payment discounting 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.

   To determine which surgical procedure code receives 100 percent of the Medicare reimbursement payment rate and which receives 50 percent, the rank assigned by Medicare is reviewed for each surgery code billed on the disputed date of service. Per a review of the Medicare 2025 ASC addendum AA, of the four CPT codes billed on August 21, 2025, CPT code 11012 is found to have the highest reimbursement rank. Therefore, the disputed CPT code 11012 shall receive 100 percent of the Medicare reimbursement payment rate, while the other three CPT codes each receive 50 percent of the Medicare payment rate. Maximum allowable reimbursement (MAR) amounts with multiple procedure discounting applied for each CPT code billed on the disputed date are shown below.

   Procedure Code 11012 has a payment indicator of A2 indicating that payment is based on OPPS relative payment weight.

   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 CPT code 11012** on the applicable date of

service is $1,201.90.

- The Medicare ASC reimbursement is divided by 2 = $600.95.
- This number multiplied by the CBSA index of 1.0189, for Houston-The Woodlands-Sugar Land, TX region = $ 612.308.
- Add these two together = $1,213.258, which is the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT 11012, multiply the geographically adjusted Medicare ASC rate of $1,213.258 by the DWC payment adjustment factor of 235% = $2,851.156.
- DWC finds that the MAR for CPT code 11012 rendered on August 21, 2025, is $2,851.16.

Procedure Code 14040 has a payment indicator of A2 indicating that payment is based on OPPS' relative payment weight.

- The Medicare ASC reimbursement **for CPT code 14040** on the applicable date of service is $981.09.
- The Medicare ASC reimbursement is divided by 2 = $490.545.
- This number multiplied by the CBSA index of 1.0189, for Houston-The Woodlands-Sugar Land, TX region = $499.816.
- Add these two together = $990.361, which is the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT 14040, multiply the geographically adjusted Medicare ASC rate of $990.361 by the DWC payment adjustment factor of 235% = $2,327.348.
- Because this procedure was furnished in the same session as another primary procedure, CPT code 14040 is subject to MPPR discounting; therefore, the MAR is fifty percent of $2,327.348, or $1,163.674.
- DWC finds that the MAR for CPT code 14040 rendered on August 21, 2025, is $1,163.67 with multiple procedure payment discounting applied.

Procedure Code 26236 has a payment indicator of A2 indicating that payment is based on OPPS relative payment weight.

- The Medicare ASC reimbursement **for CPT code 26236** on the applicable date of service is $838.29.
- The Medicare ASC reimbursement is divided by 2 = $419.145.
- This number multiplied by the CBSA index of 1.0189, for Houston-The Woodlands-Sugar Land, TX region = $427.067.
- Add these two together = $846.212, which is the geographically adjusted Medicare ASC rate.

- To determine the MAR for CPT 26236, multiply the geographically adjusted Medicare ASC rate of $846.212 by the DWC payment adjustment factor of 235% = $1,988.598.
- Because this procedure was furnished in the same session as another primary procedure, CPT code 26236 is subject to MPPR discounting; therefore, the MAR is fifty percent of $1,988.598, or $994.299.
- DWC finds that the MAR for CPT code 26236 rendered on August 21, 2025, is $994.30 with multiple procedure payment discounting applied.

Procedure Code 11760 per 2025 ASC Addendum AA is assigned a payment indicator P3, which indicates an Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) non-facility PE RVUs; payment is based on 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 11760** is $182.36.
- 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 August 21, 2025.
- The disputed service was rendered in zip code 77027, locality 18, "Houston."
- The non-facility Medicare participating amount for CPT code 11760 on the disputed date of service at this locality is $182.36.
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor on the applicable date of service is 32.3465.
- Using the above formula, DWC finds the MAR is $395.65 for CPT code 11760 on the disputed date of service.

DWC finds that the **total MAR** for surgical services rendered in an ASC setting on the disputed date of service, August 21, 2025, is $5,404.78.

4. The requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $7,187.00 for CPT code 11012 rendered on August 21, 2025.

   As demonstrated in finding number three above, DWC finds that in accordance with DWC Rule 28 TAC §134.402, the total MAR for the disputed date of service is $5,404.78.

   A review of the submitted EOBs finds that the insurance carrier previously reimbursed the requester for a total amount of $2,300.71. Therefore, additional reimbursement in the amount of $3,104.07 is recommended.

   DWC finds that the requester is entitled to additional reimbursement in the amount of $3,104.07.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor 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 $3,104.07.

ORDER

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed service. It is ordered that the Respondent, Sompo America Insurance Co., must remit to the Requester, Occu-Health Surgery Center, $3,104.07 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 20, 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.