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

General Information

Requester Name
Gulf Coast Orthopedics

Respondent Name
Zurich American Ins Co of Illinois

MFDR Tracking Number
M4-26-0530-01

Insurance Carrier's Austin Representative
BOX 19 Flahive Ogden & Latson

DWC Date Received
October 27, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 14, 2025	11012	$3,759.00	$0.00
July 14, 2025	13132	$2,721.00	$0.00
July 14, 2025	29125	$404.00	$56.03
	Total	$6,884.00	$56.03

Requester's Position

"This dispute arises from improper bundling and denial of CPT 11012 …, 13132 …, and 29125. The carrier applied multiple-surgery edits without identifying the specific NCCI pairings or modifier indicator policy. The operative report demonstrates distinct and separately billable procedures performed during an emergent operation…"

Amount In Dispute: $6,884.00

Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. Supplemental response will be provided once the bill auditing company has finalized their review."

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

1. 59 & 90121 - Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
2. 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
3. P12 – Workers' compensation jurisdictional fee schedule adjustment.
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. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Do the disputed services contain National Correct Coding Initiative (NCCI) edit conflicts that could have an impact on reimbursement?
4. Is modifier "59" supported by the medical documentation as appended to the disputed CPT codes?
5. Is the requester entitled to reimbursement or additional reimbursement for the services in dispute?

Findings

1. This medical fee dispute involves professional charges for surgery services rendered on July 14, 2025, in an ambulatory surgical center facility. Specifically, DWC will consider the non-payment of procedure codes 11012, 13132, and 29125 in the presence of other surgical procedure codes billed on the same date of service.

   DWC will review the disputed procedure codes in accordance with applicable DWC rules and statutes to determine if reimbursement is due to the requester.

2. As stated in finding number one, this medical fee dispute involves professional charges for surgical services rendered on July 14, 2025, in a licensed ambulatory surgical center. As the disputed CPT codes represent professional medical services, DWC finds that Rule 28 TAC Section 134.203(b)(1) applies to the services in dispute, stating in pertinent part, "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."

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-F6**, **11012-59-F6**, 26746-59-F6, 26418-59-F8, **13132-59-F6**, **29125-59-RT**. (disputed codes in bold font)

   DWC completed NCCI edits and found the following edit conflicts:

   - CPT code **11012** has an unbundle relationship with history procedure code **13132**. Review documentation to determine if a modifier is appropriate.
   - CPT code **13132** has an unbundle relationship with history procedure code 26746. Review documentation to determine if a modifier is appropriate.
   - CPT code **13132** has an unbundle relationship with history procedure code 26418. Review documentation to determine if a modifier is appropriate.
   - CPT code **13132** has an unbundle relationship with history procedure code **29125**. Review documentation to determine if a modifier is appropriate.
   - CPT code **29125** has an unbundle relationship with history procedure code 26746. Review documentation to determine if a modifier is appropriate.
   - CPT code **29125** has an unbundle relationship with history procedure code 26418. Review documentation to determine if a modifier is appropriate.
   - CPT code **29125** has an unbundle relationship with history procedure code **11012**. Review documentation to determine if a modifier is appropriate.
   - According to NCCI Procedure-to-Procedure Lookup site, all of the disputed CPT code combinations have a modifier policy indicator of "1" indicating that the use of a modifier is allowed to override NCCI conflicts when supported by documentation.

4. A review of the submitted medical bill finds that the requester appended disputed CPT codes 11012, 13132, and 29125 with modifier "59" to indicate that the procedure or service was distinct or independent from other non-evaluation and management (E/M) services performed on the same day.

    - 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."

      DWC notes that 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."
    - 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 29125 is described as "Application of short arm splint (forearm to hand); static."

    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.

    The requester charged $3,759.00 each for one unit of CPT code 11012-F6 and one unit of 11012-59-F6. In its review of the submitted operative report, DWC finds that the medical documentation supports the use of modifier "59" appended to one unit of CPT code 11012 as defined. The insurance carrier has previously allowed reimbursement in the amount of $577.71 for one unit of CPT code 11012-59-F6 and allowed $0.00 for one unit of CPT code 11012-F6. Therefore, in the subsequent findings, DWC will review and adjudicate one unit of CPT code 11012-59-F6 to determine if the requester is entitled to additional reimbursement.

A review of the submitted medical bill finds that the requester appended modifier "59" to one unit of CPT code 13132. The insurance carrier previously allowed $0.00 reimbursement for this disputed code. Although the modifier policy indicator of "1" allows for a modifier to override the NCCI edits for this procedure code, a review of the submitted operative report finds that the charge for CPT code **13132 is not supported as defined** in the medical documentation. DWC finds that there is a more appropriate CPT code for the billing of the service documented in the operative report. Therefore, DWC cannot recommend reimbursement for CPT code 13132 on the disputed date of service.

A review of the submitted medical bill finds that the requester charged for one unit of CPT code 29125-59-RT. The insurance carrier denied reimbursement for this code asserting that this service is included in another service that was billed on the same date. A review of the submitted operative report supports the use of modifier "59" appended to CPT code 29125 to indicate a separately identifiable service and to override the NCCI edit, as is allowed by modifier policy indicator of "1". Therefore, DWC finds that the requester is entitled to separate reimbursement for CPT code 29125-59-RT. The maximum allowable reimbursement (MAR) for CPT code 29125-59-RT will be calculated and adjudicated in subsequent findings.

5. The requester is seeking reimbursement in the amount of $6,884.00 for professional charges for surgical services rendered on July 14, 2025, in a licensed ambulatory surgical center.

   As indicated in the previous finding, CPT codes 29125-59-RT and 11012-59-F6 qualify for further review and calculation of the MAR. Therefore, DWC will calculate the MAR for reimbursement of one unit of CPT code 29125-59-RT and the MAR for additional reimbursement of one unit of CPT code 11012-59-F6.

   DWC finds that 28 TAC Section 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".

DWC finds that disputed CPT codes 29125 and 11012 both have a multiple procedure indicator of "2". A review of the submitted medical report supports that multiple surgical procedures were performed on July 14, 2025, within the same surgical session, by the same healthcare provider. As a result, the multiple procedure payment adjustment at 50 percent of the applicable fee schedule amount will be applied when calculating the MAR for the disputed CPT codes 29125 and 11012.

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

CPT code 29125-59-RT:

- The disputed service was rendered in zip code 77027, locality 18, "Houston."
- The Medicare participating amount for CPT code 29125 in 2025, rendered in a facility setting at this locality is $41.13.
- The multiple procedure adjustment applies at 50% of the Medicare fee amount; therefore, the applicable multiple procedure fee for CPT code 29125 on the disputed date of service is $20.57.
- 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 $56.03 for CPT code 29125 on July 14, 2025, rendered in a facility setting in locality 18.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $56.03 is recommended for CPT code 29125 rendered on July 14, 2025, in a facility setting.

CPT code 11012-59-F6:

- The disputed service was rendered in zip code 77027, locality 18, "Houston."
- The Medicare participating amount for CPT code 11012 in 2025, rendered in a facility setting at this locality is $424.22.
- The multiple procedure adjustment applies at 50% of the Medicare fee amount;

therefore, the applicable multiple procedure fee for CPT code 11012 on the disputed date of service is $212.11.

- 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 $577.71 for CPT code 11012 on July 14, 2025, rendered in a facility setting in locality 18.
- The respondent paid $577.71 for this disputed CPT code.
- Additional reimbursement is not recommended for disputed CPT code 11012-59-F6 rendered on July 14, 2025, in a facility setting.

DWC finds that the requester is entitled to additional reimbursement in the total amount of $56.03 for CPT code 29125-59-RT.

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 Ins Co of Illinois must remit to Gulf Coast Orthopedics $56.03 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	January 29, 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. 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.

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 electronico CompConnection@tdi.texas.gov.