



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Jason R. Bailey, M.D., PA

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-26-0900-01

Insurance Carrier's Austin Representative

BOX 15 Downs Stanford PC

DWC Date Received

November 28, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 14, 2025	26356	\$20,584.11	\$4,471.91
May 14, 2025	64831	\$5,955.95	\$975.66
May 14, 2025	11012	\$5,528.74	\$577.71
May 14, 2025	11011	\$4,247.02	\$0.00
May 14, 2025	13132	\$7,990.34	\$0.00
May 14, 2025	12002	\$973.33	\$0.00
May 14, 2025	29125	\$580.04	\$56.03
May 14, 2025	76000	\$362.18	\$0.00
Total		\$46,221.71	\$6,081.31

Requester's Position

"Our claim was processed and reimbursed a partial payment of \$13,884.88 plus \$94.80 in interest. EOB received shows CPT codes 26356, 64831, 11012, 11011, 13132, 12002, 29125, 76000 denied. Dr. Bailey was consulted for medically necessary EMERGENCY surgery... Failure to perform the medically necessary 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: \$46,221.71

Respondent's Position

"The Carrier issued an Explanation of Benefits and payment to the Provider, which has been deposited as documented on the payment summary. The Provider has been reimbursed for the disputed services. The Carrier has reviewed the Maximum Allowable Reimbursement calculation and contends no additional reimbursement is due."

Response Submitted By: Constitution State Services

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. 4063 - REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING.
2. 78 - THE ALLOWANCE FOR THIS PROCEDURE WAS ADJUSTED IN ACCORDANCE WITH MULTIPLE SURGICAL PROCEDURE RULES AND/OR GUIDELINES.
3. 3244 -THE BILLING OF THE PROCEDURE CODE HAS EXCEEDED THE NATIONAL CORRECT CODING INITIATIVE MEDICALLY UNLIKELY EDITS AMOUNT FOR THE NUMBER OF TIMES THIS PROCEDURE CAN BE BILLED ON A DATE OF SERVICE. AN ALLOWANCE HAS NOT BEEN PAID.
4. 3247 - BILLING OF THE PROCEDURE CODE HAS EXCEEDED THE NATIONAL CORRECT CODING INITIATIVE MEDICALLY UNLIKELY EDITS AMOUNT FOR THE NUMBER OF TIMES

THIS PROCEDURE CAN BE BILLED ON A DATE OF SERVICE. THE CORRECT USE OF A MODIFIER TO REPORT THE SAME CODE ON A SEPARATE LINE PERMITS AN ADDITIONAL UNIT OF SERVICE TO BE ALLOWED. SINCE THE MODIFIER HAS NOT BEEN USED CORRECTLY, AN ADDITIONAL UNIT CANNOT BE PAID.

5. 3245 - BILLING OF THE PROCEDURE CODE HAS EXCEEDED THE NATIONAL CORRECT CODING INITIATIVE MEDICALLY UNLIKELY EDITS AMOUNT FOR THE NUMBER OF TIMES THIS PROCEDURE CAN BE BILLED ON A DATE OF SERVICE ON ANOTHER BILL. AN ALLOWANCE HAS NOT BEEN PAID.
6. 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.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Have any of the services in dispute been allowed reimbursement as of the date of this medical fee dispute resolution (MFDR) review?
4. Is the insurance carrier's reimbursement reduction of CPT code 26356-ET-F7 and 26356-ET-F8 based on multiple surgical procedure rules supported?
5. Is the insurance carrier's denial of CPT code 26356-ET-F9 based on medically unlikely edits (MUE) supported?
6. Is the requester entitled to additional reimbursement for CPT code 26356?
7. Is the insurance carrier's denial of CPT code 64831-ET-RT based on MUE supported?
8. Is the requester entitled to reimbursement for CPT code 64831-ET-RT?
9. Is the use of modifier "59" as appended to CPT codes 11012 and 11011 supported?
10. Is the requester entitled to reimbursement for CPT codes 11012-59-F7 and 11011-59-F8?
11. Is the use of modifier "59" as appended to CPT code 13132 supported? If so, is the requester entitled to reimbursement?
12. Is the use of modifier "59" as appended to CPT code 12002 supported? If so, is the requester entitled to reimbursement?
13. Is the use of modifier "59" as appended to CPT code 29125 supported? If so, is the requester entitled to reimbursement?
14. Is the requester entitled to reimbursement for CPT code 76000-ET-59?
15. Is the requester entitled to additional reimbursement for the professional surgery services in dispute rendered on May 14, 2025, in an inpatient setting?

Findings

1. This medical fee dispute involves professional surgery services rendered on May 14, 2025, in

an acute care hospital facility setting.

In its position statement, the requester acknowledges, and the submitted explanation of benefits (EOB) confirms, that the services in dispute have previously received partial reimbursement. This partial reimbursement is not reflected in the "Amount Paid" field of the submitted DWC Form-060, *Medical Fee Dispute Resolution Request* (DWC Form-060).

According to the submitted DWC Form-060, the requester is seeking additional reimbursement in the amount of \$46,221.71. DWC will review the submitted documentation from both parties in accordance with the applicable DWC rules to determine if additional reimbursement is due.

2. The surgery services in dispute are professional medical services rendered in a hospital facility setting. DWC finds that 28 TAC Section 134.203, which sets out the fee guideline for professional medical services, applies to the billing and reimbursement of the disputed services.

28 TAC Section 134.203(b)(1) states, "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 explanation of benefits (EOB) dated October 13, 2025, finds that CPT code 26356-ET-F7 x 3 units has received reimbursement in the amount of \$3,353.88 and that CPT code 26356-ET-F8 x 3 units has received reimbursement in the amount of \$2,235.91.

According to a review of the submitted medical bill, the requester charged \$20,584.11 each for three units of CPT code 26356-ET-F7 and three units of 26356-ET-F8. The requester additionally charged \$13,722.74 for two units of 26356-ET-F9 which received \$0.00 reimbursement allowance. These are **the only disputed procedure codes** found to have received reimbursement according to the submitted EOB.

DWC finds that the services in dispute, specifically CPT code 26356, have received reimbursement in the total amount of \$5,589.79.

Per review of the submitted DWC Form-060, the requester is seeking additional reimbursement in the amount of \$20,584.11 for CPT code 26356, modifiers not specified. DWC will review the documentation submitted in accordance with the applicable DWC rules to determine if the requester is entitled to additional reimbursement for CPT code 26356.

4. According to the submitted EOB, the insurance carrier reduced payment for three units of CPT code 26356-ET-F7 and three units of 26356-ET-F9 based on multiple surgical

procedure rules.

A review of the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, section 40.6 - Claims for Multiple Surgeries, CMS defines multiple surgeries as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. 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
- If more than five procedures with an indicator of "2" are billed, pay for the first five according to the rules listed above and suspend the sixth and subsequent procedures for manual review and payment... Payment for these codes should never be lower than 50 percent of the full payment amount.

Medicare pays for multiple surgeries by ranking from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical code is based on 50% of the MPFS amount. To determine which surgeries are subject to the multiple surgery rules, the rank assigned by Medicare is reviewed for each surgery code.

CPT code 26356 is described as "Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath; primary, without free graft, each tendon" and has a multiple surgery indicator of "2" which indicates that standard multiple surgery discounting applies.

Since multiple units of CPT code 26356 were billed on the same date of service with multiple other surgical procedure codes, DWC finds that the multiple surgery discounting rule applies to the disputed CPT codes 26356-ET-F7 and 26356-ET-F9 rendered on May 14, 2025.

DWC finds that the insurance carrier's reimbursement reduction reason of CPT codes 26356-ET-F7 and 26356-ET-F9 is supported. DWC will review these disputed procedure codes further in the following findings to determine if additional reimbursement is due.

5. According to the submitted EOB, the insurance carrier denied reimbursement for CPT code 26356-ET-F9 based on MUE stating that the number of units billed has exceeded the allowed number of units per date of service.

Per Medicare payment policy regarding Medically Unlikely Edits, these edits were implemented by Medicare in 2007. MUE's set a maximum number of units for a specific service that a provider would report under most circumstances for a single patient on a single date of service. Medicare developed MUE edits to detect potentially medically unnecessary services.

Although DWC adopts Medicare payment policies by reference in applicable Rule 28 TAC Section 134.203, paragraph (a)(7) of that rule states that specific provisions contained in the Division of Workers' Compensation rules shall take precedence over any conflicting provision adopted by the Medicare program.

The Medicare MUE payment policy is in direct conflict with Texas Labor Code Chapter 413.014 which requires that all determinations of medical necessity shall be made prospectively or retrospective through utilization review; and with Rule 28 TAC Section 134.600 which sets out the procedures for preauthorization and retrospective review of professional services such as those in dispute here. DWC concludes that Labor Code Chapter 413.014 and 28 TAC Section 134.600 take precedence over Medicare MUE. Therefore, DWC finds that the insurance carrier's denial reason based on MUE is not supported.

6. The requester is seeking additional reimbursement in the amount of \$20,584.11 for CPT code 26356. As demonstrated in finding number three, CPT codes 26356-ET-F7 and 26356-ET-F8 have previously received reimbursement in the total amount of \$5,589.79.

On the dispute date of service, the requester billed CPT codes 26356-ET-F7 x 3 units, 26356-ET-F8 x 3 units, and 26356-ET-F9 x 2 units, for a total of 8 units of CPT code 26356, in addition to other surgical procedure codes billed on the same date.

CPT code 26356 is described as "Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath; primary, without free graft, each tendon" and has a multiple surgery indicator of "2" which indicates that standard multiple surgery discounting applies.

Out of the surgical services rendered on the disputed date of service, CPT code 26356 has the highest MPFS amount. Therefore, the first unit shall receive 100 percent of MPFS amount and subsequent units shall be adjusted to fifty percent of the MPFS amount.

DWC finds that 28 TAC Section 134.203(c) applies to the reimbursement of CPT code 26356, stating in pertinent part, "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. 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..."

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The disputed service was rendered in zip code 77598, locality 18, "Houston."

- The Medicare participating amount for CPT code 26356 in 2025, rendered in a facility setting at this locality is \$820.93.
- 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 \$2,235.91 for the first unit of CPT code 26356 rendered in a facility setting in locality 18 in 2025.
- The requester charged a total of 8 units of CPT code 26356. The Medicare multiple surgery discounting rule applies. As a result, the seven subsequent units will receive fifty percent of the MPFS amount, or \$410.47 per unit.
- Using the above formula, DWC finds the MAR is \$1,117.97 per unit; DWC finds the MAR is \$7,825.79 for seven subsequent units of CPT code 26356.
- DWC finds that the total MAR for 8 units of CPT code 26356 rendered on May 14, 2025, in a facility setting is \$10,061.70.
- The insurance carrier previously paid \$5,589.79.
- Additional reimbursement in the amount of \$4,471.91 is recommended for 8 units of CPT code 26356 rendered on May 14, 2025, in a facility setting.

7. According to the submitted EOB, the insurance carrier denied reimbursement for CPT code 64831-ET-RT based on MUE stating that the number of units billed has exceeded the allowed number of units per date of service.

As discussed in finding number five, the Medicare MUE payment policy is in direct conflict with Texas Labor Code Chapter 413.014 and that Labor Code Chapter 413.014 and 28 TAC Section 134.600 take precedence over Medicare MUE. Therefore, DWC finds that the insurance carrier's denial reason based on MUE is not supported.

8. The requester is seeking reimbursement in the amount of \$5,955.95 for CPT code 64831-ET-RT rendered on May 14, 2025.

CPT code 64831 is described as "Suture of digital nerve, hand or foot; 1 nerve" and has a multiple surgery indicator of "2" which indicates that standard multiple surgery discounting applies.

DWC finds that 28 TAC Section 134.203(c), as quoted above, applies to the reimbursement of CPT code 64831-ET-RT.

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The disputed service was rendered in zip code 77598, locality 18, "Houston."
- The Medicare participating amount for CPT code 64831 in 2025, rendered in a

facility setting at this locality is \$716.44.

- The Medicare multiple surgery discounting rule applies, therefore 64831 will receive fifty percent of the MPFS amount, or \$358.22.
- 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 \$975.66 for the one unit of CPT code 64831 rendered in a facility setting in locality 18 in 2025.
- The insurance carrier paid \$0.00.
- Reimbursement in the amount of \$975.66 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of \$975.66 for one unit of CPT code 64831-ET-RT rendered on May 14, 2025, in a facility setting.

9. On the disputed date of service, the requester billed for surgical CPT codes 11012-59-F7 and 11011-F9-F8 in addition to other surgical codes billed on the same date. A review of the submitted EOB finds that the insurance carrier denied reimbursement for these procedure codes stating that the value of the procedures was included/bundled with the value of another procedure performed and billed on the same day.

DWC completed National Correct Coding Initiative (NCCI) edits and found the following edit conflicts:

- Procedure Code 11012 has an unbundle relationship with history procedure code 13132, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure code 11012 has an unbundle relationship with history procedure code 13131, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 11011 has an unbundle relationship with history procedure code 20103, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 11011 has an unbundle relationship with history procedure code 13132, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 11011 has an unbundle relationship with history procedure code 13131, billed on the same date; Review documentation to determine if a modifier is appropriate.

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**" and has a multiple surgery indicator of "2" indicating that standard multiple surgery discounting applies.

CPT code 11011 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, and muscle" and has a multiple surgery indicator of "2" indicating that standard multiple surgery discounting applies.

The requester appended CPT codes 11012 and 11011 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. [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 documentation supports the use of modifier "59" as appended to the disputed CPT code 11012 on the submitted medical bill.

DWC finds that the submitted operative report documentation does not support the use of modifier "59" as appended to disputed CPT code 11011.

10. The requester is seeking reimbursement in the amount of \$5,528.74 for CPT code 11012-59-F7 and is seeking \$4,247.02 for CPT code 11011-59-F8.

Because the use of modifier "59" as appended to CPT code 11011 is not supported, DWC finds that the requester is not entitled to reimbursement for this procedure code.

Because the use of modifier "59" as appended to CPT code 11012 is supported, DWC finds that the requester is entitled to reimbursement for this procedure code. Therefore, DWC will calculate the MAR for CPT code 11012-59-F7 rendered on May 14, 2025, in a facility setting.

DWC finds that 28 TAC Section 134.203(c), as quoted above, applies to the reimbursement of CPT code 11012-59-F7.

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The disputed service was rendered in zip code 77598, 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 Medicare multiple surgery discounting rule applies; therefore, CPT code 11012 will receive fifty percent of the MPFS amount, or \$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 the one unit of CPT code 11012-59-F7 rendered in a facility setting in locality 18 in 2025.
- The insurance carrier paid \$0.00.
- Reimbursement in the amount of \$577.71 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of \$577.71 for CPT code 11012-59-F7 rendered in a facility setting on May 14, 2025.

11. On the date of service in dispute, the requester billed for surgical CPT code 13132-ET-59-RT in addition to other surgical codes billed on the same date. A review of the submitted EOB finds that the insurance carrier denied reimbursement for this procedure code stating that the value of the procedures was included/bundled with the value of another procedure performed and billed on the same day.

DWC completed NCCI edits and found the following edit conflicts:

- Procedure code 13132 has an unbundle relationship with history procedure code 26356, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure code 13132 has an unbundle relationship with history procedure code 35207, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 13132 has an unbundle relationship with history procedure code 64831, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 13132 has an unbundle relationship with history procedure code 26727, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 13132 has an unbundle relationship with history procedure code 26776, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure code 13132 has an unbundle relationship with history procedure code 20103, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 13132 has an unbundle relationship with history procedure code 29125, billed on the same date; Review documentation to determine if a modifier is appropriate.

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**" and has a multiple surgery indicator of "2" indicating that standard multiple surgery discounting applies.

The requester appended CPT code 13132 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. See finding number nine for more information about modifier "59".

A review of the submitted operative report documentation finds that the use of modifier "59" as appended to disputed CPT code 13132 is not supported in the narrative report as the CPT code is defined. As a result, reimbursement cannot be recommended.

DWC finds that the requester is not entitled to reimbursement for CPT code 13132-ET-59-RT as billed on the disputed date of service, May 14, 2025.

12. On the disputed date of service, the requester billed for surgical CPT code 12002-ET-59-F6 in addition to other surgical codes billed on the same date. A review of the submitted EOB finds that the insurance carrier denied reimbursement in for this procedure code stating that the value of the procedures was included/bundled with the value of another procedure performed and billed on the same day.

DWC completed NCCI edits and found the following edit conflicts:

- Procedure Code 12002 has an unbundle relationship with history procedure code 64831, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 12002 has an unbundle relationship with history procedure code 20103, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 12002 has an unbundle relationship with history procedure code 29125, billed on the same date; Review documentation to determine if a modifier is appropriate.

CPT code 12002 is described as "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); **2.6 cm to 7.5 cm**" and has a multiple surgery indicator of "2" indicating that standard multiple surgery discounting applies.

The requester appended CPT code 12002 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. See finding number nine for more information about modifier "59".

A review of the submitted operative report documentation finds that the use of modifier

"59" as appended to disputed CPT code 12002 is not supported in the narrative report as the CPT code is defined. As a result, reimbursement cannot be recommended.

DWC finds that the requester is not entitled to reimbursement for CPT code 12002-ET-59-F6 as billed on the disputed date of service, May 14, 2025.

13. On the disputed date of service, the requester billed for CPT code 29125-ET-59-RT in addition to other surgical procedure codes billed on the same date. A review of the submitted EOB finds that the insurance carrier denied reimbursement in for this procedure code stating that the value of the procedures was included/bundled with the value of another procedure performed and billed on the same day.

DWC completed NCCI edits and found the following edit conflicts:

- Procedure Code 29125 has an unbundle relationship with history procedure code 64831, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure code 29125 has an unbundle relationship with history procedure code 26727, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure code 29125 has an unbundle relationship with history procedure code 26776, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 29125 has an unbundle relationship with history procedure code 11012, billed on the same date; Review documentation to determine if a modifier is appropriate.
- Procedure Code 29125 has an unbundle relationship with history procedure code 11011, billed on the same date; Review documentation to determine if a modifier is appropriate.

CPT code 29125 is described as "Application of short arm splint (forearm to hand); static" and has a multiple surgery indicator of "2" indicating that standard multiple surgery discounting applies.

The requester appended CPT code 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. See finding number nine for more information about modifier "59".

Per review of the submitted operative report DWC finds that documentation supports the use of modifier "59" as appended to the disputed CPT code 29125 on the submitted medical bill.

Because the use of modifier "59" as appended to CPT code 29125 is supported, DWC finds that the requester is entitled to reimbursement for this procedure code. Therefore, DWC will calculate the MAR for CPT code 29125-ET-59-RT rendered on May 14, 2025, in a facility

setting.

DWC finds that 28 TAC Section 134.203(c), as quoted above, applies to the reimbursement of CPT code 29125-ET-59-RT.

To determine the MAR the following formula is used:

$(\text{DWC Conversion Factor} / \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$.

- The disputed service was rendered in zip code 77598, 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 Medicare multiple surgery discounting rule applies; therefore, CPT code 29125 will receive fifty percent of the MPFS amount, or \$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 one unit of CPT code 29125-ET-59-RT rendered in a facility setting in locality 18 in 2025.
- The insurance carrier paid \$0.00.
- Reimbursement in the amount of \$56.03 is recommended.

DWC finds that the requester is entitled to reimbursement in the amount of \$56.03 for CPT code 29125-ET-59-RT rendered in a facility setting on May 14, 2025.

14. On the disputed date of service, the requester charged for one unit of CPT code 76000-ET-59. Per review of the submitted medical bill, the place of service code is "21" which indicates an inpatient hospital setting.

Per Medicare guidelines, procedure code 76000 describes a diagnostic procedure that requires a professional component modifier when rendered in place of service "21". Further information regarding the professional component modifier can be found at [Modifier 26 Fact Sheet](#).

A review of the submitted medical bill finds that a professional component modifier is not appended to CPT code 76000. As a result, DWC cannot recommend reimbursement.

DWC finds that the requester is not entitled to reimbursement for CPT code 76000-ET-59 rendered on May 14, 2025, in an inpatient hospital setting.

15. Per MFDR review of the disputed procedure codes in accordance with DWC applicable Rules and Statues, DWC finds that the requester, Jason R. Bailey, M.D., PA, is entitled to

additional reimbursement in the total amount of \$6,081.31 for professional surgical services rendered in an inpatient hospital setting on May 14, 2025.

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 Indemnity Insurance Co. of North America must remit to Jason R. Bailey, M.D., PA \$6,081.31 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

_____	_____	February 9, 2026
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 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 electrónico CompConnection@tdi.texas.gov.