



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Texas Tech University Health Science Center

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-1441-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

January 21, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 22, 2025	25295	\$1,133.00	\$694.61
Total		\$1,133.00	\$694.61

Requester's Position

"Our findings contradict this denial due to the ... being done at a separate location than the ... Lines 2 and 3 are coded with appropriate separately identifiable modifiers. Line 2 is coded with modifier LT. Line 3 however is coded with modifier XS and LT to indicate it's for a separate structure, still on the left side... According to the Medicare modifier fact sheet, modifier XS is used to report a "separate structure, a service that is distinct because it was performed on a separate structure."

Amount In Dispute: \$1,133.00

Respondent's Position

"CPT code 25301 is a primary code and CPT code 25295 is a secondary code. For both to be payable on the same date of service, the operative report must specify that 25301 ... and 25295 ... were performed on different ... The operative report does specify that both the volar (front) and

dorsal (back) aspects of the ... were operated on, it does not specify that separate ... were operated on. Our position is that no additional payment is due.”

Response Submitted By: Texas Mutual

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

The insurance carrier denied payment for the disputed services with the following reasons:

1. 435 - PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
2. 236 -THIS BILLING CODE IS NOT COMPATIBLE WITH ANOTHER BILLING CODE PROVIDED ON THE SAME DAY ACCORDING TO NCCI OR WORKERSCOMPENSATION STATE REGULATIONS/FEE SCHEDULE REQUIREMENTS.
3. 193 & 891 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
4. W3 -IN ACCORDANCE WITH TDI-DWC RULE 134.804, THS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Is the insurance carrier's denial based on National Correct Coding Initiative (NCCI) edits supported?
4. Is the requester entitled to reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) review involves non-payment of a professional charge for a surgical procedure rendered on January 22, 2025, in an outpatient hospital facility. Specifically, surgery procedure code 25295 was not allowed reimbursement and is

the only procedure code in dispute.

The insurance carrier allowed reimbursement for other surgery procedure codes on the medical bill and denied separate payment for CPT code 25295 due to a NCCI edit conflict with another surgery procedure code billed on the same date. The requester appended the disputed CPT code 25295 with modifier "XS" to override the NCCI edit conflict.

In this MFDR review, DWC will consider whether the insurance carrier's denial reason is supported and whether the requester is entitled to separate reimbursement for disputed CPT code 25295 in accordance with applicable DWC Statutes and Rules.

2. Because the service in dispute is considered a professional medical service, 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."
3. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied CPT code 25295 stating that per NCCI edits, the value of CPT code 25295 is included in the value of the comprehensive procedure code billed on the same day.

A review of the submitted medical bill finds that on the date of service in dispute the requester charged for the following CPT codes: 14040, 25301-LT, 25295-XS-LT, and 26608-LT. DWC completed NCCI edits and found that "Per Medicare CCI Guidelines, procedure code 25295 has an unbundle relationship with history procedure code 25301; Review documentation to determine if a modifier is appropriate." An appropriate modifier is allowed to override the NCCI edit conflict in this case, if the medical record supports the use of the modifier.

The requester appended the disputed procedure code, 25295, with modifier "XS" which indicates "Separate **structure**, a service that is distinct because it was performed on a separate organ/**structure**." More information about the proper use of this modifier can be found at [MLN1783722 - Proper Use of Modifiers 59, XE, XS, XP & XU](#).

CPT code 25295 is described as "Tenolysis, **flexor or extensor** tendon, forearm and/or wrist, **single, each tendon**."

CPT code 25301 is described as "Tenodesis at wrist; **extensors** of fingers."

A review of the submitted operative report documents that CPT code 25295 was performed on flexor tendon **structures**, while CPT code 25301 was performed on extensor tendon **structures**. Although both procedures were performed in the wrist region, flexor and

extensor tendons are **separate anatomical structures**.

CMS/NCCI policy permits the use of modifier XS when procedures are performed on distinct anatomical **structures**, even if within the same anatomical region. CMS does not require that the services be performed on separate flexor tendons; rather, it requires documentation supporting that the services were performed on different anatomical **structures**, which is supported in this case.

DWC finds that the use of modifier "XS" appended to CPT code 25295 is supported by the medical documentation to override the NCCI edit conflict unbundle relationship to CPT code 25301. As a result, DWC finds that the insurance carrier's reason for denial based on the NCCI edit conflict is not supported.

4. The requester is seeking reimbursement in the amount of \$1,133.00 for professional medical surgical service represented by CPT code 25295-XS-LT rendered on January 22, 2025, in an outpatient hospital facility setting. Because the insurance carrier's reason for denial is not supported, DWC finds that the requester is entitled to reimbursement. Therefore, DWC will adjudicate for the maximum allowable reimbursement (MAR) for CPT code 25295-XS-LT rendered on January 22, 2025.

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 a 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, 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 January 22, 2025, within the same surgical session, by the same healthcare provider. CPT code 25301 is the primary procedure code performed on the disputed date of service and receives the highest fee amount. Both procedure codes have a multiple procedure indicator of "2", therefore, the multiple procedure payment adjustment will be

applied when calculating the MAR for the disputed CPT code 25295-XS-LT.

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 79415, locality 99, "Rest of Texas"
- The Medicare participating amount for CPT code 25295 in January of 2025, rendered in a facility setting at this locality is \$510.06.
- The multiple procedure adjustment applies at 50% of the Medicare fee amount; therefore, the applicable multiple procedure fee for CPT code 25295 on the disputed date of service is \$255.03.
- 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 \$694.61 for CPT code 25295-XS-LT on January 22, 2025, rendered in a facility setting in locality 99.
- The respondent paid \$0.00 for this disputed CPT code.
- Reimbursement of \$694.61 is recommended for CPT code 25295-XS-LT rendered on January 22, 2025, in a facility setting.

DWC finds that the requester is entitled to reimbursement in the amount of \$694.61 for the disputed surgery CPT code 25295-XS-LT rendered on January 22, 2025, in a facility setting.

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 reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Company must remit to Texas Tech University Health Science Center \$694.61 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

February 27, 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 electrónico CompConnection@tdi.texas.gov.