TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Summit Orthopedics of Texas

Respondent Name

City of Arlington

MFDR Tracking Number

M4-26-2133-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

March 10, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2025	29888	$2,860.00	$1,643.77
	Total	$2,860.00	$1,643.77

Requester's Position

"Preauthorization was issued before surgery. The carrier paid other services from the same date of service but denied CPT 29888. Reconsideration was requested, and the original payment decision was maintained. Provider requests DWC review and additional reimbursement for CPT 29888."

Amount In Dispute: $2,860.00

Respondent's Position

The Austin carrier representative for City of Arlington is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on April 2, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 service with the following reasons:

1. 411 – National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day.
2. 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure modifier combination provided on the same day according to the NCCI edits or work comp state regs/fee schedule requirements.
3. 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. Is the insurance carrier's denial based on National Correct Coding Initiative (NCCI) edits conflicts supported?
4. What is the maximum allowable reimbursement (MAR) for the services rendered on the date in question?
5. Is the requester entitled to additional reimbursement?

Findings

1. This medical fee dispute resolution (MFDR) request involves professional surgery services provided in an ambulatory surgical center (ASC) on April 25, 2025. Specifically, the requester is seeking reimbursement for procedure code 29888-59 which was billed with two additional surgical procedure codes on the same date of service. The two additional surgical codes have been reimbursed and are not in dispute. The requester has been previously reimbursed in the total amount of $2,142.03 for services rendered on April 25, 2025.

   DWC will review the submitted documentation to determine if the requester is entitled to separate and additional reimbursement for procedure code 29888-59 in accordance with applicable DWC Statutes and Rules.

2. Because the service in dispute is considered a professional medical service, DWC finds that 28 TAC Section 134.203 applies to the billing and reimbursement of the disputed service.

   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) finds that the insurance carrier denied procedure code 29888 based on an NCCI edit conflict.

   A review of the submitted medical bill finds that on the disputed date of service the requester billed for the following procedure codes: **29888-59**, 27427, and 20900 **(disputed code in bold font).**

   DWC completed NCCI edits and found the following edit conflicts:

   - Per Medicare CCI Guidelines, procedure code 29888 has an unbundle relationship with history procedure code 27427. *Review documentation to determine if a modifier is appropriate*.

   - No other procedure code combinations on the medical bill were found to have NCCI edit conflicts.

   - According to NCCI Procedure-to-Procedure Lookup site, **CPT code combinations 29888 and 27427** have a modifier policy indicator of "1" indicating that **the use of a modifier is allowed** to override NCCI conflict **when supported by documentation**.

   CPT code 29888 is described as "Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction… For an anterior cruciate ligament reconstruction (29888), a 5 cm to 12 cm incision is made on the anterior lower patella and upper tibia. A tunnel is drilled through the tibia into the knee joint. A second tunnel is drilled from inside

the knee joint, through the femur. With the aid of the arthroscope for visualization, a new ligament graft is placed in the tibial tunnel and positioned inside the knee joint.

CPT code 27427 is described as "Ligamentous reconstruction (augmentation), knee; extra-articular… In 27427, an extra-articular augmentation is performed on one or more of the stabilizing ligaments external to the knee joint that are damaged or torn. The physician makes an incision over the affected ligament. The torn end may be attached to the bone using anchors, staples, or a screw and washer or the tear may be repaired and attached to the bone using a graft. Commonly, the patient's own tendon is harvested to be used as the graft material."

DWC notes that both of the above described CPT codes may be reported together when both are documented in the medical record. A modifier may be required.

The requester appended modifier "59" to CPT code 29888 on the submitted medical bill. 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.

A review of the submitted medical record finds that the operative report supports that both procedures described above were performed and documented on the same date of service.

DWC finds that the submitted operative report supports the use of modifier "59" as appended to the disputed CPT code 29888 on the submitted medical bill. Consequently, DWC finds that the insurance carrier's reason for denial of CPT code 29888-59 rendered on April 25, 2025, is not supported.

4. The requester is seeking additional reimbursement in the amount of $2,860.00 for procedure code 29888-59 rendered on April 25, 2025.

   Because the insurance carrier's reason for denial reason of CPT code 29888-59 is not supported, DWC finds that the disputed procedure code is eligible for adjudication and calculation of the MAR in accordance with 28 TAC Section 134.203 for the disputed date of service.

   DWC Rule 28 TAC Section 134.203(c) 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 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

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 codes 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.

As previously noted, on the disputed date of service the requester billed the insurance carrier for CPT codes **29888-59**, 27427, and 20900. All surgical procedure codes billed on the disputed date of service were performed by the same physician and have a multiple procedure status indictor of 2, which represents "standard payment adjustment rules for multiple procedures apply." In this case, procedure code 29888 has the highest MPFS value amount, therefore, this code will receive reimbursement at 100% of the MPFS amount and the subsequent codes will receive reimbursements at 50% of the MPFS amount.

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

- The disputed services were rendered in zip code 76092, locality 28, "Fort Worth."
- The Medicare participating amount **for procedure code 29888** in 2025, rendered in a facility setting at this locality is $953.08.
- The 2025 Surgery DWC Conversion Factor is 88.1.
- On the disputed date of service, the Medicare Conversion Factor is 32.3465.
- Using the above formula, DWC finds the MAR at 100% of MPFS amount is $2,595.84 for **procedure code 29888** on April 25, 2025, rendered in a facility setting in locality 28.

- The Medicare participating amount **for procedure code 27427** in 2025, rendered in a facility setting at this locality is $699.12.
- The 2025 Surgery DWC Conversion Factor is 88.1.
- On the disputed date of service, the Medicare Conversion Factor is 32.3465.
- Using the above formula, DWC finds the MAR is $1,904.15 for procedure code 27427.
- The MPPR rate at 50% of the MAR is $952.08 **for procedure code 27427** on April 25, 2025, rendered in a facility setting in locality 28.

- The Medicare participating amount **for procedure code 20900** in 2025, rendered in a facility setting at this locality is $174.68.
- The 2025 Surgery DWC Conversion Factor is 88.1.
- On the disputed date of service, the Medicare Conversion Factor is 32.3465.
- Using the above formula, DWC finds the MAR is $475.76 for procedure code 20900.
- The MPPR rate at 50% of the MAR is $237.88 **for procedure code 20900** on April 25, 2025, rendered in a facility setting in locality 28.

- DWC finds that the total MAR with application of the Medicare multiple surgery procedures discounting rule is $3,785.80 for professional medical surgery services rendered on April 25, 2025, in a facility setting.
- The insurance carrier paid a total amount of $2,142.03.
- Additional reimbursement in the amount of $1,643.77 is recommended.

DWC finds that the requester is entitled to additional reimbursement in the amount of $1,643.77 for professional surgery services rendered in a facility setting on April 25, 2025.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 City of Arlington must remit to Summit Orthopedics of Texas $1,643.77 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	June 30, 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.