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

Occu Health Surgery Center

Respondent Name

Sentry Casualty Co

MFDR Tracking Number

M4-26-2669-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

May 26, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 14, 2025	11012	$1,412.23	$1,412.23
	Total	$1,412.23	$1,412.23

Requester's Position

"The carrier denied and/ or reduced reimbursement asserting the documentation does not support the level of service and/ or that the claim was correctly processed. A timely reconsideration request was submitted; however, the dispute remains unresolved."

Amount In Dispute: $1,412.23

Respondent's Position

"We reviewed the bill and determined it has been processed correctly. CPT 11012 is denied as per AMA the code is only reported separately when gross contamination requires extensive cleansing and removal of appreciable amounts of debris, devitalized and/or contaminated tissue, when there is foreign matter removed, and the wound is contaminated by foreign matter that requires extensive excisional debridement. The documentation does not support billing 11012. After additional

review of the documentation, 11012 is not supported. There is no mention of contamination of foreign material (such as dirt) in the OP note."

Response Submitted By: Sentry

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 134.402 sets out the guidelines for ambulatory surgical centers.

Adjustment Reasons

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

1. P12 – Workers' compensation jurisdictional fee schedule adjustment.
2. 59 – Processed based on multiple or concurrent procedure rules.
3. 150 – Payer deems the information submitted does not support this level of service.
4. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
5. W3 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
6. N130 - Consult plan benefit documents/guidelines for information about restrictions for this service.
7. Comments: Per AMA CPT code 11012 is only reported separately when gross contamination requires extensive cleansing and removal of appreciable amounts of debris, devitalized and/or contaminated tissue, when there is foreign matter removed, and the wound is contaminated by foreign matter that requires extensive excisional debridement. The documentation does not support billing 11012. After additional review of the documentation, 11012 is not supported. There is no mention of contamination of foreign material (such as dirt) in the OP note. Original audit stands.

CCL - THIS BILL WAS REVIEWED BY A SPECIALTY AUDIT/CODING EXPERT BY APPLYING CODE AUDITING RULES /\ND EDITS BASED ON CODING CONVENTIONS DEFINED BY AMA AND CODING GUIDELINES DEVELOPED BY NATIONAL SOCIETIES AND PREVAILING INDUSTRY STANDARDS AND CODING PRACTICES.

CRU - THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

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 of the procedure code in dispute supported?
4. Is the requester entitled to reimbursement for the procedure code in dispute?

Findings

1. This medical fee dispute resolution request (MFDR) involves non-payment of procedure code 11012 billed by an ambulatory surgical center (ASC) on July 14, 2025. On the same date of service, the ASC requester billed other surgical procedure codes which are not in dispute. The requesting ASC facility has previously been reimbursed in the total amount of $3,952.52 for the date of service in question.

   DWC will review the submitted documentation to determine if the requester is entitled to reimbursement of the disputed procedure code in accordance with applicable DWC Statutes and Rules.

2. Because this medical fee dispute involves surgical services rendered in a licensed ASC, DWC finds that Rule 28 TAC Section 134.402 applies to the billing and 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 14, Section 10.2, 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.

3. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied separate payment for procedure code 11012 based on lack of medical documentation to support the level of service billed.

In its position statement, the respondent states, "…per AMA the code is only reported separately when gross contamination requires extensive cleansing and **removal of** appreciable amounts of debris, **devitalized and/or contaminated tissue**, when there is foreign matter removed, and the wound is contaminated by foreign matter that requires extensive excisional debridement. The documentation does not support billing 11012… There is no mention of contamination of foreign material (such as dirt) in the OP note."

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."

Regarding CPT code 11012, DWC notes that Medicare LCD reference Article - Billing and Coding: Wound Care (A53001) states in pertinent part, "Debridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable. However, debridement of tissue **at the site of an open fracture** or dislocation **may be reported separately** with CPT codes 11010-11012."

Although the denial reason did not include National Correct Coding Initiative (NCCI) edit conflicts, DWC completed NCCI edits and found that no conflicts exist between procedure code 11012 and any of the other procedure codes billed on the same date.

A review of the submitted medical report finds that the service of procedure code 11012 as defined above was performed and documented in the presence of an open fracture on the disputed date of service. The medical record further documents that devitalized, contaminated tissue was sharply excised at the site of an open fracture. Therefore, the respondent's position statement is not supported.

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

4. The requester, a licensed ambulatory surgical center, is seeking reimbursement in the amount of $1,412.23 for procedure code 11012 rendered on July 14, 2025. Because the insurance carrier's reason for denial is not supported, DWC finds that the disputed procedure code is eligible for reimbursement in accordance with the applicable Rule 28 TAC Section 134.402.

   Per the ASC addendum AA for the applicable date of service, DWC finds that all procedure codes billed on July 14, 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 CPT codes billed on July 14, 2025, CPT code 26765 is found to have the highest reimbursement rank. Therefore, the disputed CPT code 11012 shall receive 50 percent of the Medicare reimbursement payment rate. Maximum allowable reimbursement (MAR) amount with multiple procedure discounting applied for CPT code 11012 billed on the disputed date is 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.
- Multiple procedure discounting rule applies to CPT code 11012 in this case; therefore, CPT code 11012 will receive 50 percent of the Medicare reimbursement amount which is $600.95.
- Fifty percent of the Medicare ASC reimbursement of $600.95 is divided by 2 = $300.475.
- This number multiplied by the CBSA index of 1.0189, for Houston-The Woodlands-Sugar Land, TX region = $ 306.154.
- Add these two together = $606.629, which is fifty percent of the geographically adjusted Medicare ASC rate.
- To determine the MAR for CPT 11012, multiply fifty percent of the geographically adjusted Medicare ASC rate of $606.629 by the DWC payment adjustment factor of 235% = $1,425.578.
- DWC finds that the MAR for CPT code 11012 rendered on July 14, 2025, is $1,425.58.
- The requester is seeking $1,412.23. This amount of reimbursement is recommended.

DWC finds that the requester, Occu Health Surgery Center, is entitled to reimbursement in the amount of $1,412.23.

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 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 service. It is ordered that Sentry Casualty Co. must remit to Occu Health Surgery Center $1,412.23 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		June 30, 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 electronico CompConnection@tdi.texas.gov.