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

General Information

Requestor Name
JASON RICHARD BAILEY MD PA

Respondent Name
SENTRY SELECT INSURANCE COMPANY

MFDR Tracking Number
M4-23-0762-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 28, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 3, 2022	20103 and 76000	$3,418.80	$0.00
	Total	$3,418.80	$0.00

Requestor's Position

"Our claim was processed and denied reimbursement per EOB received, codes 20103 and 76000 denied due to payer deems the information submitted does not support this level of service... We then submitted a corrected claim changing the 80 modifier to the AS modifier. All codes billed for this claim allow for an assistant surgeon. I am attaching a copy of the documentation that was submitted for this claim. Please review the documents attached; both the reconsideration and corrected claim documentation is included for your review."

Amount in Dispute: $3,418.80

Respondent's Position

"CPT codes 20103 and 76000 both have a status indicator for assistant at surgery of 0, meaning payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity. In closing, the documentation did not support reporting or reimbursement for codes 20103 or 76000, Appending of modifier 59 was inappropriately applied, AS modifier was not supported by the documentation, Optum does not dispute the need for treatment and did not dispute payment based on medical necessity of services but rather on the correct coding and reporting."

Response Submitted by: Optum

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 342-ASSISTANT SURGEON PAYS PERCENTAGE OF FEE SCHEDULE VALUE.
- 350- BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 375-PLEASE SEE SPECIAL *NOTE* BELOW.
- CCL-CLINICAL CODING LOGIC • SEE BILL COMMENTS BELOW .
- CRU- RE-EVALUATION, NO ADDITIONAL ALLOWANCE - SEE NOTES BELOW.
- A90-THIS CHARGE WAS REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.
- W3- IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- P12-WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 150-PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
- 193- ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- NOTE: CPT 20103 - 29881 has a status indicator of 0, therefore, documentation must not only support work performed by the assistant but the medical necessity requiring assistant. Documentation submitted did not support medical necessity. The use of we can indicate anyone within the operative suite and does not warrant reimbursement. The submitted operative report only indicated the name of the assistant at surgery. The role and necessity of the assistant are not documented. Per the AMA, The American College of Surgeons Statements on Principles II, AAOS, and the AAPC all Indicate that documentation must Indicate the role and necessity of the assistant-at-surgery. Documentation must demonstrate that the assistant Is actively participating in the surgery and performing more than ancillary services. No services were cited or did not demonstrate services that are above and beyond ancillary services that could not have been performed by a lower credentialed individual provided by the facility at no charge. CPT 76000 – A
- CCL· THIS BILL WAS REVIEWED BY A SPECIALTY AUDIT/CODING EXPERT BY APPLYING CODE AUDITING RULES AND EDITS BASED ON CODING CONVENTIONS DEFINED BY AMA AND CODING GUIDELINES DEVELOPED BY NATIONAL SOCIETIES AND PREVAILING INDUSTRY STANDARDS AND CODING PRACTICES.

Issues

1. Is the insurance carrier's denial reason(s) supported?
2. Is the Requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT 20103 and 76000 rendered on May 3, 2022. The insurance carrier denied/reduced the disputed services with denial reduction codes indicated above.

   28 TAC §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."

   The requestor billed 20103-ET-AS-59 and 76000-ET-AS-59 on May 3, 2022:

   - CPT Code 20103 is described as, "Exploration of penetrating wound (separate procedure); extremity."
   - CPT Code 76000 is described as, "Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time."
   - Modifier -ET is described as, "Emergency services."
   - Modifier -AS is described as, "Physician assistant nurse practitioner, or clinical nurse specialist services for assistant at surgery."
   - Modifier -59 is described as, "Distinct Procedural Service."

   The DWC finds that CPT Codes 20103 and 76000 both contain an assistant surgery indicator "0." Review of the CMS MLN901344-March 2021, page 28 defines indicator "0" "Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity."

   The DWC finds that the disputed services were not subject to the preauthorization requirements set out in 28 TAC §134.600, as the surgical procedure was coded utilizing modifier -ET defined as "Emergency services." As a result, medical necessity has been established as the disputed services were considered a medical emergency.

   Review of the medical documentation identifies the -AS modifier on the operative report, however, does not document the assistant surgeon's role during the operative session rendered on May 3, 2022. The DWC finds that the insurance carrier's denial reasons are supported and therefore the requestor is not entitled to reimbursement for the services in dispute.

2. The DWC finds that the requestor is not entitled to reimbursement for the services in dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		March 21, 2023
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 §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 1-800-252-7031, option 3 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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.