



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Jason R. Bailey, M.D. PA

Respondent Name

Ace American Insurance Co.

MFDR Tracking Number

M4-24-2107-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

May 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 18, 2023	15004, 11047, 15005	\$4,130.50	\$0.00
	Total	\$4,130.50	\$0.00

Requestor's Position

"EOB received shows CPT codes 15004, 11047 and 15005 denied due to multiple physicians/ assistants not covered. [name of assistant] was consulted for medically necessary EMERGENT surgery... Failure to perform the medically necessary EMERGENT surgery could have resulted in placing the patient's health in serious jeopardy..."

Amount in Dispute: \$4,130.50

Respondent's Supplemental Position

"The provider's DWC 60 includes the carrier's EOB dated April 2, 2024, and the recommended payment of \$443.91. It remains the carrier's position that the provider has been paid 100% of what he is entitled to. No additional monies are owed."

Response Submitted by: Flahive, Ogden & Latson

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 Texas Administrative Code \(TAC\) §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 denied payment for the disputed services with the following claim adjustment codes:

- 54 & 90116 – Multiple physicians/assistants are not covered in this case.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 259 – Additional payment for Dental/Vision service utilization.
- 00663 – Reimbursement has not been calculated according to state fee schedule guidelines.
- 98 – Assistant surgeon services not warranted for this procedure.
- 247 - Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
- 90202 & B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What rules apply to the billing and reimbursement of the disputed services?
2. Is the Insurance Carrier's denial reason(s) supported?
3. Is the Requestor entitled to additional reimbursement?

Findings

1. This dispute involves professional medical surgical services rendered in an inpatient hospital facility, place of service 21. DWC finds that [28 TAC §134.203](#) which sets out the fee guideline for professional medical services, applies to the billing and reimbursement of the services in dispute.

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."

2. A review of the medical bills submitted finds that the requestor charged a total amount of \$6,156.70 for surgical services billed under the CPT codes 15004-AS-LT, 11044-76-59-LT, 11047-AS-76-59-LT, and 15005-AS-LT.

A review of the explanation of benefits (EOB) finds that the insurance carrier allowed reimbursement in the amount of \$443.91 for CPT code 11044-76-59-LT. The insurance carrier denied reimbursement for disputed CPT codes 15004-AS-LT, 11047-AS-76-59-LT, and 15005-AS-LT based on "assistant at surgery not covered or not warranted in this case."

The CPT codes in dispute are related to surgery services and are described as follows:

- CPT 15004 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits...
- CPT 11047 - Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure).
- CPT 15005 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof...

The requestor appended each of the disputed CPT codes with modifier "AS" indicating physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery. The requestor additionally appended the disputed CPT code 11047 with modifier "59" indicating that the procedure was distinct or independent from other services performed on the same day.

As described in the Medicare [Assistant at Surgery Modifier Fact Sheet](#) (updated August 30, 2023), code status indicators are to be used to determine if the procedure is allowed with the assistance of a second surgeon.

DWC finds that all three of the disputed CPT codes have an "Assistant at Surgery" status indicator of "0", indicating that "payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity." The supporting documentation must be submitted at the time of claim submission to establish medical necessity and should clearly document the assistant surgeon's role during the operative session.

A review of the operative report submitted finds documentation does not clearly describe the role of the assistant during the operative procedure or that an assistant performed a distinct, independent procedure on the date of service in dispute. Therefore, the documentation does not meet the requirement to overcome the payment restrictions of "Assistant at Surgery" status indicator of "0" for CPT codes 15004, 11047, 15005.

DWC finds that the insurance carrier's denial reason of CPT codes 15004, 11047, and 15005, which were all appended with modifier "AS", is supported.

3. The requestor is seeking additional reimbursement in the total amount of \$4,130.50 for surgical services rendered on December 18, 2023. Because the insurance carrier's reason for denial, based on "assistant at surgery not covered in this case," is supported, DWC finds that the requestor is not entitled to additional reimbursement for the disputed services.

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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

_____	_____	July 9, 2024
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 managing the claim. If you have questions about DWC Form-045M, 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 electrónico CompConnection@tdi.texas.gov.