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

Requestor Name
Jason R. Bailey, M.D. PA

Respondent Name
Ace American Insurance Co.

MFDR Tracking Number
M4-24-2108-01

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
January 10, 2024	20680 and 11047	$11,053.90	$0.00
	Total	$11,053.90	$0.00

Requestor's Position

"EOB received shows CPT codes 20680 and 11047 denied due to multiple physicians/assistants not covered. [name of assistant] was consulted for medically necessary EMERGENT surgery…"

Amount in Dispute: $11,053.90

Respondent's Supplemental Position

"The EOB dated April 3, 2024, recommended payment of $475.24. It remains the carrier's position that it has reimbursed the provider the amount required under the medical fee guidelines. The EOB explains the carrier's position. No additional payment is 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.
- 00663 – Reimbursement has 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.
- 104 – Managed care withholding.

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 $13,080.10 for surgical services billed under the CPT codes 20680-AS-78-ET-LT, 11044-78-59-LT, and 11047-AS-78-59-LT.

   A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier allowed reimbursement in the amount of $475.24 for CPT code 11044-78-59-LT. The insurance carrier denied reimbursement for disputed CPT codes 20680-AS-78-ET-LT and 11047-AS-78-59-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 20680 - Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate).
   - 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).

   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 both 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 20680 and 11047.

   DWC finds that the insurance carrier's denial reason of CPT codes 20680 and 11047, which were both appended with modifier "AS", is supported.

3. The requestor is seeking additional reimbursement in the total amount of $11,053.90 for surgical services rendered on January 10, 2024. 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.

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 electronico CompConnection@tdi.texas.gov.