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
Jason R. Bailey, MD, PA

Respondent Name
American Casualty Company of Reading

MFDR Tracking Number
M4-25-0707-01

Carrier's Austin Representative
Box Number 57

DWC Date Received
November 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 16, 2024	20103-AS-ET-59-F1, and 76000-AS-ET-59	$5,160.94	$0.00

Requester's Position

"Our claim was submitted on 09/09/2024 in the amount of $5,160.94 and was denied payment by CNA for 'Radiology report required' for code 76000, however, the fluoroscopy was used during the procedure to make sure we could see the location of the bone and make sure it was in the proper place. You also paid for it on the primary surgeon's claim, therefore, it should be paid on our claim. Per NCCI Edits and modifiers, codes 20103 and 76000 are allowable codes and allow for an assistant when using modifier AS. We are requesting that you reprocess the claim and reimburse our provider for the medically necessary EMERGENCY service…. Failure to perform the procedure could have resulted in placing the patient's health in serious jeopardy or serious impairment to bodily functions or even serious dysfunction of bodily organs.

Based on the information provided, I am requesting that this claim be manually reprocessed and pay codes 20103 and 76000 accordingly; it should allow correct payment for an assistant for a medically necessary case."

Amount in Dispute: $5,160.94

Respondents' Position

"After a review by Conduent's Clinical Validation team based on the treatment notes submitted with the CPT codes. The requirements were not met as per the AMA's CPT guidelines.
Upon receipt of the documentation for this MDR Medical Fee Dispute, Carrier again sent the documentation for review by Conduent Bill Review. Condent[*sic*] Bill Review Services maintains that no additional allowable is due as the documentation submitted by the provider does not support a surgery assistant for these services as per the AMA CPT guidelines. Specifically:"

54 - MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE.
98 - ASSISTANT SURGEON SERVICES NOT WARRANTED FOR THIS PROCEDURE.
W3 - BILL IS A RECONSIDERATION OR APPEAL.
193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
1014 - 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.
2005 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION."

Response Submitted by: Law office of Brian J. Judis

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 16 -Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 256 - Billing of modifier is not appropriate for services performed.
- 309 - The charge for this procedure exceeds the fee schedule allowance.

- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 4599 - Radiology report required for processing.
- 54 - Multiple physicians/assistants are not covered in this case.
- 98 - Assistant surgeon services not warranted for this procedure.
- W3 - bill is a reconsideration or appeal.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 - 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.
- 2005 - No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the requester entitled to reimbursement for services rendered by the Physician Assistant (PA)?

Findings

1. This dispute concerns the nonpayment of procedures code 20103 and 76000, rendered on August 16, 2024. The insurance company denied the PA expenses, stating that the assistant surgeon services are not warranted.

   The requester states in their position statement, "Failure to perform the procedure could have resulted in placing the patient's health in serious jeopardy or serious impairment to bodily functions or even serious dysfunction of bodily organs."

   The division applies 28 TAC §134.203 to evaluate if CMS policies allow physician assistant charges for CPT codes 20103 and 76000. The medical bill contained the following modifiers.

   - ET – Emergency services
   - AS – Identifies services rendered by Physician Assistants (PAs), Nurse Practitioners (NPs), or Clinical Nurse Specialists (CNS) when assisting in surgery as non-team members. This means they are not directly employed by the operating surgeon and provide independent clinical judgment and skills during the procedure.
   - 59 – Distinct procedure services. 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. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

   The DWC finds that the justification for billing separate/distinct procedures using modifier 59 was not supported by the documentation.

28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

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 division finds that procedure codes 20103 and 76000 both contain an assistant surgery status indicator "0-Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity."

A review of the operative report finds that the requester documented that the services were rendered, however did not include documentation to support why this procedure required a physician's assistant.

The division finds that the requester has not established that reimbursement is due. Because the insurance carrier's denials are supported the requester is not entitled to reimbursement for procedure codes 20103 and 76000 provided on August 16, 2024.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 the Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 18, 2025 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, 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.