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

General Information

Requester Name
Jason R. Bailey, MD, PA

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-25-0755-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 3, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 23, 2024	20100-AS	$5,090.14	$110.30

Requester's Position

"Our claim was processed and reimbursed a partial payment of $600.13. EOB received shows CPT code 20100 denied due to "This service/procedure requires that a qualifying service/procedure be received and covered." Haley Shaffer was called in to assist for medically necessary EMERGENT surgery for a right mandibular fracture sustained after being struck by another vehicle on the side of the road while setting up giant lights for his job. Failure to perform the medically necessary EMERGENT surgery could have resulted in placing the patient's health in serious jeopardy or serious impairment to bodily functions or even serious dysfunction of a bodily organ. We submitted a reconsideration on 10/31/2024 for CPT code 20100 and no additional payment was made. I am attaching all the documentation regarding this claim for your review. Please review the documents attached and reconsider reprocessing our claim.

Based on the information provided, I am requesting that this claim be reviewed and reprocessed; accordingly, it should allow correct payment for the denied code 20100 for EMERGENT surgery."

Amount in Dispute: $5,090.14

Respondents' Position

"Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy. Accordingly, pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized. PA assistant-at-surgery services at 80 percent of the lesser of the actual charge or 85 percent of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6 percent of the amount paid to physicians. The AS modifier must be reported on the claim form when billing PA assistant-at-surgery services."

Response Submitted by: Gallagher Bassett

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:

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 90204, B15-1 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 299 – This service is an integral part of total service performed and does not warrant separate procedure charge.
- 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting.
- 90202, B13-2 – Previously paid. Payment for this claim/service may have been provided in previous payment.

- 247 –Deductible for professional service rendered in an institutional setting and billed on an institutional claim.

Issues

1. Do the disputed charges contain CCI edit conflicts that may potentially affect reimbursement?
2. Is the requester entitled to reimbursement for services rendered by the Physician Assistant (PA)?

Findings

1. This dispute involves the nonpayment of CPT code 20100, which was rendered on September 23, 2024. The insurance carrier denied reimbursement, asserting that the procedure is integral to a broader service and requires a qualifying primary service to be eligible for payment.

   The DWC applies 28 TAC §134.203 for services provided on this date to assess whether the billed services, 21470-AS-ET, 21244-AS-ET-59, and 20100-AS-ET, contain National Correct Coding Initiative (NCCI) edit conflicts that might affect reimbursement. Modifier descriptions are as follows:

   - ET – Emergency services
   - AS – Indicates that the service was provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) acting as a surgical assistant, but not as a team member employed by the operating surgeon.
   - 59 – Used to identify distinct procedural services that are not normally reported together but are justified under specific circumstances (e.g., different session, site, or surgical area)

   According to 28 TAC §134.203(a)(5), Medicare payment policies include coding, billing, and reimbursement methodologies as defined by the Centers for Medicare & Medicaid Services (CMS). Under §134.203(b)(1), these Medicare payment policies, including CCI edits and modifier use, apply to services provided under the Texas workers' compensation system.

   A review of the NCCI edits confirms that CPT codes 21470, 21244, and 20100 do not trigger edit conflicts when billed together. Additionally, the documentation submitted also supports that the billed services were rendered as stated.

   According to Medicare guidelines, CPT code 20100 has an assistant-at-surgery status indicator of "2", meaning that assistant-at-surgery services are payable. Per Medicare Claims Processing Manual (Chapter 12, Section 120.1), assistant-at-surgery services performed by NPs or CNSs are reimbursed at 13.6% of the Medicare Physician Fee Schedule (MPFS) amount, when appropriate.

   The division finds that for the reasons indicated above, the requester has established that reimbursement is due.

Under 28 TAC §134.203(c)(1), to determine the Maximum Allowable Reimbursement (MAR) for professional medical services, participants in the Texas workers' compensation system must apply Medicare payment policies with minimal modification. The rule further provides that for services categorized as Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery—when performed in an office setting—the applicable conversion factor is $53.68.

According to the Medicare Claims Processing Manual, Chapter 12, Section 120.1 (Rev. 2656, Issued 02-07-13), Medicare law under Section 1833(a)(1)(O) of the Social Security Act authorizes payment for services rendered by Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) when they act as an assistant-at-surgery. For these services to qualify, the NP or CNS must play an active clinical role in the surgical procedure, providing more than ancillary support.

Medicare payment policy specifies that reimbursement for NP and CNS assistant-at-surgery services is calculated at 80% of the lesser of the actual charge or 85% of the 16% that a physician would receive under the Medicare Physician Fee Schedule for similar assistant-at-surgery services. In effect, this results in payment equal to 13.6% of the amount paid to physicians for the procedure.

When billing for these services, only the AS modifier is required on the claim form to identify that the provider is functioning as a nonphysician surgical assistant.

To determine the MAR the following formula is used: (DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment Amount = MAR).

- Date of service: September 23, 2024
- The 2024 DWC Surgery Conversion Factor is 85.12
- The 2024B Medicare Conversion Factor is 33.2875
- A review of the medical bills finds that the disputed services were rendered in zip code 77339; the Medicare locality is "Houston."
- The Medicare Participating amount for CPT code 20100 at this locality is $634.31.
- Using the above formula, the DWC finds the MAR is $1,622.00.
- The multiple surgery procedure rule applies, $1,622.00/2 = $811.00
- 13.6% of $811.00 = MAR of $110.30.
- Gallagher Basett indicates the MAR is $110.30, however no EOBs were submitted to support that a payment was issued.
- The respondent paid $0.00.
- Reimbursement of $110.30 is recommended.

The DWC finds that the requester is entitled to reimbursement for the disputed services. As a result, $110.30 is due.

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 established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requester $110.30 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		July 18, 2025
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, 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.