



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Jason R Bailey MD PA

Respondent Name

Old Republic Insurance Co

MFDR Tracking Number

M4-25-1958-01

Carrier's Austin Representative

Box Number 44

DWC Date Received

April 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2024	21356	\$4,665.73	\$0.00

Requester's Position

"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 organs. We submitted a reconsideration on 11/27/2024 but still no payment was made on code 21356. Please note, per AAPC Codify, code 21356 is an allowable code with no CCI edits and allows for assistant when using modifier AS."

Supplemental response dated July 11, 2025

"We have not received payment for THIS case, which is for..., the Assistant Surgeon (AS modifier used on claim form). The payment received was for the Primary Surgeon.... Please continue with the dispute resolution for the Assistant Surgeon."

Amount in Dispute: \$4,665.73

Respondent's Position

The respondent did not submit a position statement with the request for MFDR. They did

submit the following through MDR Inquiry on May 20, 2025, "Optum has addressed the attached dispute and has reviewed and paid the claim for dos 09/10/24 and check has been cashed, see attached eob and cancelled check copy. Once you have verified the information please have dispute withdrawn and closed."

Response Submitted by: Stratacare

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:

- 54 – Multiple physician/assistants are not covered in this case.
- 98 – Assistant surgeon services not warranted for this procedure.
- TXW3 – Bill is a reconsideration or appeal.
- TXP12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX54 – Multiple physicians/assistants are not covered in this case.
- TX 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Are the insurance carrier's denials supported?
2. Is the requester entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for assistant at surgery services rendered in September of 2024. DWC Rule 28 TAC §134.203 (b) (1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a

service is provided with any additions or exceptions in the rules.”

Review of the [CMS Physician Fee Schedule](#) found the Assistant at Surgery Indicator to be “0”. The applicable Medicare Claims Processing Manual 100-04, Chapter 23 Section 50.6 at www.cms.gov - states.

- Assistant at Surgery (Modifiers AS, 80, 81, and 82)
- This field provides an indicator for services where an assistant at surgery may be paid:
- 0 = Payment restrictions for assistants at surgery applies to this procedure unless supporting document is submitted to establish medical necessity.

Review of the submitted “Operative Report” did not include any mention of an assistant at surgery or the reason an assistant at surgery was required.

The DWC finds that the requestor has not established that reimbursement is due for CPT code 21356-AS rendered on September 10, 2024.

As a result, \$0.00 is recommended.

Conclusion

Based on the evidence presented by both the requester and respondent at the time of adjudication, and upon review of applicable Texas Workers' Compensation rules and Medicare policies, the Division of Workers' Compensation finds:

- The billed services required additional information to support the necessity of an assistant at surgery. The submitted operative report did not indicate either.
- The insurance carrier’s denials were made in accordance with established coding and reimbursement rules.
- Therefore, the requester is not entitled to any additional reimbursement, and the amount due is \$0.00.

Although not all submitted evidence is discussed in detail, it was fully considered in reaching this determination.

Order

Under 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 24, 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, please call CompConnection at 1-800-252-7031, option three 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 tres o correo electrónico CompConnection@tdi.texas.gov.