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, MD PA

Respondent Name
Midwest Insurance Co

MFDR Tracking Number
M4-25-2905-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 8, 2024	15002,15003, 97606	$3,935.75	$0.00

Requestor's Position

"We submitted reconsideration requests on 12/17/2024 and 02/04/2025 including the NCCI Edits and Modifiers showing proof an assistant surgeon is allowed for the procedure codes billed."

Amount in Dispute: $3,935.75

Respondent's Position

The Austin carrier representative for Midwest Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on July 16, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §133.305 sets out the general provisions related to dispute of medical bills

3. 28 TAC §134.203 sets out the medical fee guideline for professional services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- XW1/P12/P13 – Workers compensation state fee schedule adjustment.
- D50 – Documentation does not support this code for reimbursement. Results of professional review (RN, MD, DC, CPC, other medical professional)
- D57 – Assistant surgeon is not allowed for this procedure code or additional documentation is required to support medical necessity.
- B54 – Assistant surgeon rate applied. Maximum allowable based on a % of the surgeon's allowable fee.
- 252 – An attachment /other documentation is required to adjudicate this claim/service.
- 226 – Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.
- 350/W3 – Bill has been identified as a request for reconsideration or appeal.

Issues

1. What rules are applicable to the disputed services?

Findings

1. The requestor seeks reimbursement for assistant at surgery services rendered in October 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."

A review of the applicable CMS article related to status indicators at https://www.cms.gov/status-indicators found the following explanation for assistant at surgery payment policies.

Assistant at Surgery (Modifiers AS, 80, 81, and 82)

This field gives an indicator for services where Medicare never pays an assistant at surgery.

0 = Payment restriction for assistants at surgery applies to this procedure unless you send in supporting documentation to prove medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Medicare may not pay assistants at surgery.

2 = Payment restriction for assistants at surgery don't apply to this procedure. Medicare may pay assistants at surgery.

9 = Concept doesn't apply.-04, Chapter 23 states that status "1" means "statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid."

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 97606 with modifier "59" indicating that the procedure was distinct or independent from other services performed on the same day.

Review of the submitted medical bill found the following.

- Code 15002 – Wound prep trk/arm/leg. CMS Physician Fee Schedule indicates an Assistant at Surgery indicator of 0, supporting documentation required.
- Code 15003 – Wound prep addl 100cm. CMS Physician Fee Schedule indicates an Assistant at Surgery indicator of 0, supporting documentation required
- Code 97006 – Neg prs wnd ther dme>50sqcm. CMS Physician Fee Schedule indicates an Assistant at Surgery indicator of 0, supporting documentation required

Supporting documentation is defined at https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00144529 and states. Documentation must provide a clinical picture of the patient and include:

- The name of the assistant
- Evidence the assistant surgeon actively participated in the procedure
- Clearly document the assistant's role during the operative session:
    - Assistant's role provides more than ancillary services
- Primary surgeon's signature

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 each of the disputed codes. No payment is recommended.

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 requester 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

Signature	Medical Fee Dispute Resolution Officer	September 25, 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 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.