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

General Information

Requester Name

Jason R. Bailey, M.D.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-26-0461-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

October 10, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 16, 2024	15756	$38,638.78	$1,238.24
December 16, 2024	15758	$20,296.99	$0.00
December 16, 2024	15100	$7,393.30	$0.00
December 16, 2024	11012	$5,528.74	$0.00
December 16, 2024	28485	$9,452.68	$0.00
December 16, 2024	11011	$4,247.02	$0.00
December 16, 2024	15004	$3,327.41	$93.03
December 16, 2024	11043	$1,977.78	$0.00
December 16, 2024	15101	$12,585.44	$0.00
December 16, 2024	15005	$6,982.48	$228.41

December 16, 2024	11981	$857.31	$11.42
December 16, 2024	29515	$625.34	$0.00
December 16, 2024	11046	$8,675.10	$279.30
	Total	$120,588.37	$1,850.40

Requester's Position

"Our claim was processed and reimbursed a partial payment of $407.82. EOB's (there are two) received shows CPT codes 15756, 1504, 11043, 15005, 11981 and 11046 all denied for being previously paid. Morgan Arthur was called in to be an extra sent of hands, assist both surgeons and decrease surgical time for medically necessary EMERGENT surgery for…"

Amount In Dispute: $120,588.37

Respondent's Position

The Austin carrier representative for American Zurich Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on October 17, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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 Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

The insurance reduced or carrier denied payment for the disputed services with the following reasons:

1. 54 & 90116 - MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE.
2. 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
3. 98 - ASSISTANT SURGEON SERVICES NOT WARRANTED FOR THIS PROCEDURE.
4. 252 - AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE.
5. P12 – Workers' compensation jurisdictional fee schedule adjustment.
6. 59 & 90121 – Processed based on multiple or concurrent procedure rules.
7. 593 - THE RECOMMENDED ALLOWANCE BASED ON THE VALUE OF SURGICAL ASSISTANCE PERFORMED BY LICENSED NON-PHYSICIAN OR LICENSED PHYSICIAN.
8. 4063 - REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rules apply to the services in dispute?
3. Which disputed procedure codes are eligible for assistant at surgery reimbursement?
4. Is the requester entitled to additional reimbursement for CPT code 15758-AS-LT?
5. Is the requester entitled to reimbursement for any remaining services in dispute?

Findings

1. This medical fee dispute involves assistant at surgery services rendered on December 16, 2024, in an acute care hospital facility setting.

   A review of the submitted DWC Form-060, *Medical Fee Dispute Resolution Request* (DWC Form-060), the medical bills and the explanation of benefits (EOB), finds that procedure codes 15100, 11012, 28485, 11011, 15101 and 29515, listed in the "Table of Disputed Services" are not found on the medical bills or EOBs submitted. Therefore, these procedure codes will not be considered in this medical fee dispute resolution (MFDR) review.

   According to the submitted EOB, disputed CPT code 15758-AS-59 has received payment in the amount of $407.82. This payment is not reflected on the submitted DWC Form-060 "Table of Disputed Services". All other disputed CPT codes have received $0.00 reimbursements.

   The procedure codes to be considered in this MFDR review are 15756, 15004, 11043, 15005, 11981, 11046 and 15758.

   DWC will review the submitted documentation for resolution of this medical fee dispute in

accordance with the applicable DWC Rules.

2. The surgery services in dispute are professional medical services rendered in a hospital facility setting. DWC finds that 28 TAC Section 134.203, which sets out the fee guideline for professional medical services, applies to the billing and reimbursement of the disputed services.

   28 TAC Section 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."

3. According to a review of the submitted medical bill, the requester appended each of the disputed CPT codes, except for CPT code 11043, with modifier "AS" indicating physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery.

   As described in the Medicare Assistant at Surgery Modifier Fact Sheet, code status indicators are to be used to determine if the procedure is allowed reimbursement as an assistant at surgery service. The status indicators are defined as follows:

   - Status indicator 0 = payment restrictions for assistant at surgery applies unless supporting documentation is submitted to establish medical necessity; supporting **documentation must clearly document the assistant's role during the operative session.**
   - Status indicator 1 = Statutory payment restriction; assistant at surgery may not be paid.
   - Status indicator 2 = Payment restrictions for assistant at surgery do not apply; Assistant at surgery may be paid.
   - Status indicator 9 = Concept does not apply.

   The codes in dispute have the following "Assistant at Surgery" status indicators:

   - CPT codes 15758 and 15756 have "assistant at surgery" status indicators of "2".
   - CPT codes 15004, 15005, 11981, and 11046 have "assistant at surgery" status indicators of "0".
   - CPT code 11043 has "assistant at surgery" status indicator of "1". However, this code was not appended with "AS" modifier.

   In summary, the disputed CPT codes which are eligible for assistant at surgery reimbursements are as follows:

- CPT codes 15756 and 15758 with status indicator "2" are eligible without restriction.
- CPT codes 15004, 15005, 11981, and 11046 with status indicator "0" are only eligible if the assistant's role during the operative session is clearly documented in the operative report.
- CPT code 11043 with status indicator "1" is not eligible for assistant at surgery reimbursement.

A review of the operative report submitted finds that the role of the assistant during the operative session is clearly documented and supports reimbursement of "assistant at surgery" for the CPT codes found to be eligible as described above.

4. According to the submitted DWC Form-060, the requester is seeking reimbursement in the total amount of $20,296.99 for CPT code 15758-AS-59.

   A review of the submitted medical bill finds that the requester charged $202.96 for one unit of CPT code 15758-AS-59 rendered on December 16, 2024. A review of the submitted EOB dated March 9, 2025, finds that the insurance carrier previously allowed payment in the amount of $407.82 for this disputed CPT code. Because the insurance carrier has previously allowed reimbursement for CPT code 15758-AS-59 in an amount greater than the charged amount, DWC does not recommend additional reimbursement for CPT code 15758-AS-59 rendered on December 16, 2024, by a non-physician health care provider.

   DWC finds that the requester is not entitled to additional reimbursement for disputed CPT code 15758-AS-59 rendered on December 16, 2024.

5. The requester, a non-physician licensed health care provider, is seeking reimbursement in the total amount of $120,588.37 for assistant at surgery professional medical charges rendered in a hospital facility setting.

   As demonstrated in previous findings, the disputed CPT codes that are eligible for assistant at surgery reimbursement in this case are CPT codes 15756-AS-59, 15758-AS-59, 15004-AS-59, 15005-AS, 11981-AS, and 11046-AS-59. Because CPT code 15758-AS-59 has previously received reimbursement in an amount greater than charges, this procedure code will not be reviewed further. The remaining eligible procedure codes listed above will be reviewed for the MAR in accordance with 28 TAC Section 134.203.

   28 TAC §134.203(c), which applies to the reimbursement of the services in dispute, states in pertinent part, "To determine the maximum allowable reimbursement (MAR) for professional services, system participants shall **apply the Medicare payment policies with minimal**

modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year."

Review of the Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, section 40.6 - Claims for Multiple Surgeries, CMS defines multiple surgeries as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Per CMS, multiple surgeries are reimbursed as follows:

- 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and
- 50 percent of the fee schedule amount for the second through the fifth highest valued procedures

Medicare pays for multiple surgeries by ranking from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount.

DWC has reviewed the multiple-procedure status indicator for the procedures in question and finds the following:

- CPT code 15756 and 11981 have a multiple procedure status indicator of "2" which indicates that standard payment adjustment rules for multiple procedures apply.
- CPT codes 15004, 15005, and 11046 have a multiple procedure status indicator of "0" which indicates that no payment adjustment rules for multiple procedures apply; If you report the procedure on the same day as another procedure, payment is based on **the lower of** either the actual charge or the fee schedule amount for the procedure.

DWC finds that according to the Medicare payment policy for assistants at surgery services performed by a non-physician provider, reimbursement is 85 percent of 16 percent (i.e., 13.6 percent) of the Medicare Physician Fee Schedule amount.

To determine the MAR the following formula is used:
(DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = MAR.

The disputed services were rendered in zip code 77090, locality 18, "Houston."

For CPT code 15756 (Multiple procedure rule applies; this CPT code has the highest MPFS amount, therefore, the first unit receives 100%)

- The Medicare participating amount on the disputed date of service in 2024, rendered in a facility setting at this locality is $2,373.65 x 13.6% = $322.82.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, December 16, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $825.49 for CPT code 15756 on December 16, 2024, rendered by a non-physician assistant at surgery provider, in a facility setting, in locality 18.
- The requester billed 2 units of CPT code 15756. CPT 15756 is described as "free muscle (or myocutaneous) flap with microvascular anastomosis" and the term "free flap" indicates that the tissue is completely detached from its original blood supply and is reattached to the recipient site using microvascular techniques.
- A review of the operative report finds that the documentation supports 2 units of CPT code 15756 as defined.
- Per Medicare policy, the second unit receives 50%. Therefore, the second unit receives half of $825.49 or $412.75.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $1,238.24 is recommended for 2 units of CPT code 15756.

For CPT code 11981 (Multiple procedure discounting rule applies; receives 50% of MPFS)

- The Medicare participating amount on the disputed date of service in 2024, rendered in a facility setting at this locality is $65.69 x 13.6% = $8.93.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, December 16, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $22.84 x 50% = $11.42 for CPT code 11981 on December 16, 2024, rendered by a non-physician assistant at surgery provider, in a facility setting, in locality 18.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $11.42 is recommended.

For CPT code 15004 (Multiple procedure discounting does not apply)

- The Medicare participating amount on the disputed date of service in 2024, rendered in a facility setting at this locality is $267.47 x 13.6% = $36.38.
- The 2024 Surgery DWC Conversion Factor is 85.12.

- On the disputed date of service, December 16, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $93.03 for CPT code 15004 on December 16, 2024, rendered by a non-physician assistant at surgery provider, in a facility setting, in locality 18.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $93.03 is recommended.

For CPT code 15005 (Multiple procedure discounting does not apply)

- The Medicare participating amount on the disputed date of service in 2024, rendered in a facility setting at this locality is $93.86 x 13.6% = $12.76.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, December 16, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $32.63 for one unit of CPT code 15005 on December 16, 2024, rendered by a non-physician assistant at surgery provider, in a facility setting, in locality 18.
- The requester billed 7 units of CPT code 15005. CPT code 15005 is described as "surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm." This code is to be reported in conjunction with the primary procedure code, specifically code 15004, which covers the surgical preparation of the first 100 square centimeters.
- A review of the operative report finds that the documentation supports 7 units of CPT code 15005.
- Multiple procedure discounting does not apply to this CPT code. Therefore, the MAR for 7 units of CPT code 15005 is $32.63 x 7 = $228.41.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $228.41 is recommended.

For CPT code 11046 (Multiple procedure discounting does not apply)

- The Medicare participating amount on the disputed date of service in 2024, rendered in a facility setting at this locality is $57.37 x 13.6% = $7.80.
- The 2024 Surgery DWC Conversion Factor is 85.12.
- On the disputed date of service, December 16, 2024, the Medicare Conversion Factor is 33.2875.
- Using the above formula, DWC finds the MAR is $19.95 for one unit of CPT code 11046 on December 16, 2024, rendered by a non-physician assistant at surgery provider, in a facility setting, in locality 18.

- The requester billed 14 units of CPT code 11046. CPT code 11046 is described as "debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm; list separately in addition to code for primary procedure."
- A review of the operative report submitted finds that the documentation supports 14 units of CPT code 11046.
- Multiple procedure discounting does not apply to this CPT code. Therefore, the MAR is $19.95 x 14 units = $279.30.
- The respondent paid $0.00 for this disputed CPT code.
- Reimbursement of $279.30 is recommended.

DWC finds that the requester is entitled to additional reimbursement in the total amount of $1,850.40 for assistant at surgery services rendered on December 16, 2024, by a non-physician health care provider in a hospital facility setting.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that American Zurich Insurance Company must remit to Jason Bailey, M.D. $1,850.40 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 21, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.