



Medical Fee Dispute Resolution Findings and Decision General Information

Requestor Name
Integrity Health Clinic

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-23-1532-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
February 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 16, 2023	99214	\$9.86	\$9.86
Total		\$9.86	\$9.86

Requestor's Position

"Payments received from Sedgwick are consistently below the formula outlined by the State of Texas, 28 TAC §134.203, Chapter 12 of the Medicare Claims Processing Manual, and TIC 1451.104(c)."

Amount in Dispute: \$9.86

Respondent's Position

"The carrier's position is that the provider is not entitled to any additional payment. The starting amount of \$226.30 was multiplied by 85% based upon a non-physician discount."

Response Submitted by: Flahive, Ogden & Latson

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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and physician assistants.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 252 – The recommended allowance is based on the value for services performed by a licensed non-physician practitioner
- 309 – The charge for this procedure exceeds the fee schedule allowance
- 2008 – Additional payment made on appeal/reconsideration

Issues

1. What services are in dispute?
2. How are the disputed services reimbursed under the Texas Workers' Compensation system?
3. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor seeks additional reimbursement for professional medical services rendered on January 16, 2023. The insurance carrier reduced the payment based on non-physician practitioner and workers compensation fee schedule.

Code 99214 is defined as, "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter."

2. The requestor billed \$203.00, for an office visit rendered by a physician's assistant (PA) and the insurance carrier issued a payment in the amount of \$192.36.

The insurance carrier's reduction of payment is based on Medicare's non-physician reimbursement policies. The DWC will now consider if 80% reimbursement of the billed amount applies to PA's.

Texas Insurance Code [Sec. 1451.104](#) states in part:

- (c) Notwithstanding Subsection (a), a health insurance policy may provide for a different amount of payment or reimbursement for scheduled services or procedures performed by an advanced practice nurse, nurse first assistant, licensed surgical assistant, or physician assistant if the methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician.

This provision allows insurance carriers to reimburse physician assistants at a different amount than physicians.

DWC Rule 28 TAC [§134.203](#) Medical Fee Guideline for Professional Services, states:

(a) (5) "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.

(b) 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.

Chapter 12 of the [Medicare Claims Processing Manual](#) states, "110 - Physician Assistant (PA) Services Payment Methodology (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13) See chapter 15, section 190 of the Medicare Benefit Policy Manual, pub. 100-02, for coverage policy for physician assistant (PA) services. Physician assistant services are paid 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."

TIC 1451.104(c) allows the insurance carrier to pay a PA a different amount if the "methodology used to compute the amount is the same as the methodology used to compute the amount of payment or reimbursement when the services or procedures are provided by a physician."

A physician is paid for code 99214 at the Medicare rate plus a DWC multiplier. Reimbursing a PA at 80 percent of the actual charge is not the same methodology used for physician reimbursement and is contrary to TIC 1451.04(c). The DWC finds that the requestor is therefore entitled to 85% of the Medicare Physician Fee Schedule.

DWC Rule 28 TAC §134.203 states in pertinent part, "(c) To determine the 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...

(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..."

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

- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.06
- The CMS 1500 indicates the services were rendered in zip code 75703; the Medicare

locality is "Rest of Texas."

- The Medicare Participating amount for CPT code 99214 at this locality is \$124.36.
- 85% of the CMS Fee Schedule = Medicare Participating amount of \$105.71
- Using the above formula, the DWC finds the MAR is \$207.30
- The respondent paid \$192.36.

3. The DWC finds that the insurance carrier did not calculate the reimbursement per the fee guideline shown above. The requestor is seeking \$9.86. This amount 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. The DWC finds the requestor has established that additional reimbursement of \$9.86 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the American Zurich Insurance Co must remit to the Integrity Health Clinic \$9.86 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	April 4 2023
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, 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 electrónico CompConnection@tdi.texas.gov.