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

General Information

Requestor Name
Rio Occupational Institute

Respondent Name
AIU Insurance Co.

MFDR Tracking Number
M4-25-0916-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 24, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 14, 2024	99213	$160.00	$152.76
August 14, 2024	9980-73	$20.00	$0.00
	Total:	$180.00	$152.76

Requestor's Position

Excerpt from the Request for Reconsideration:
"Received another denial for services with the review date of 12-09-2024. I am asking assistance in getting this matter resolved since the services were provided by the treating physician and all other dates of service have been paid."

Amount in Dispute: $180.00

Respondent's Position

The Austin carrier representative for AIU Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on December 31, 2024. 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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.
3. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.
4. 28 TAC §134.600 sets out the procedures for preauthorization requirements of healthcare services.
5. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and nurse practitioners.
6. 28 TAC §129.5 sets out the fee guidelines for the DWC73 Work Status Reports.

Adjustment Reasons

- 197 – PRECERTIFICATION/AUTHORIZATIONINOTIFICATION/PRE-TREATMENTABSENT.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- XXU00 - THERE WAS NO UR PROCEDURE/TREATMENT REQUEST RECEIVED.
- XXG15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- 00663 - REIMBURSEMENT HAS BEEN CALCULATED BASED ON THE STATE GUIDELINES.
- W3 & 350 - BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Is the disputed claim governed by a network contract?
2. Is the insurance carrier's reason for reimbursement denial of CPT code 99213 supported?
3. Is the requestor entitled to reimbursement for CPT code 99213?
4. Is the requestor entitled to reimbursement for procedure code 99080-73?

Findings

1. According to a review of the submitted documentation and information known to DWC, this injured employee's Texas Worker's Compensation claim is a non-network claim. Therefore, DWC finds that the disputed claim is not governed by a network contract.

2. A review of the submitted explanation of benefits (EOB) document finds that the disputed CPT code 99213 was denied reimbursement based on lack of preauthorization/precertification.

   The office visit service in dispute, billed under CPT code 99213, is described 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 low level of medical decision making (MDM). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter."

   28 TAC §134.600(p), which sets out non-emergency health care requiring preauthorization, does not require that health care providers obtain prior authorization for the rendering of evaluation and management office visits.

   DWC finds that the insurance carrier's reason for denial of reimbursement for CPT code 99213 is not supported.

3. The requestor is seeking reimbursement for CPT code 99213 rendered by a licensed physician assistant (PA) provider on August 14, 2024.

   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.

   28 TAC §134.203 Medical Fee Guideline for Professional Services, which applies to the billing and reimbursement of the service in dispute, states in pertinent part:

   > (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…
   >
   > (h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, **reimbursement shall be the least of the**:
   >
   > > (1) MAR amount;
   > > (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

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, sections 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 physician assistant 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 CPT code 99213 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). DWC finds that the requestor is therefore entitled to the least of 85% of the Medicare Physician Fee Schedule or the provider's customary charge.

DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99213.

28 TAC §134.203(c) 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."

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

- The disputed date of service is August 14, 2024, by a licensed physician assistant (PA).
- The disputed service was rendered in zip code 78504, locality 99.
- The Medicare participating amount for CPT code 99213 on the disputed date of service in 2024 at this locality is $88.22. The MAR formula will apply 85% of that amount for the service rendered by a PA, for an adjusted Medicare amount of $74.99.
- The 2024 DWC Conversion Factor is 67.81.
- The 2024 Medicare Conversion Factor on the disputed date of service is 33.2875.
- Using the above formula, DWC finds the MAR is $152.76 for CPT code 99213 in locality 99 rendered by a licensed PA on the disputed date of service.
- The respondent paid $0.00.
- Reimbursement in the amount of $152.76 is recommended for CPT code 99213 rendered

by a licensed PA on August 14, 2024.

4. The requestor is seeking reimbursement for procedure code 99080-73 rendered on August 14, 2024.

   CPT code 99080-73 is described as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form." In this case, 99080-73 specifically refers to the rendering of DWC specific Work Status Reports.

   28 TAC §129.5 which applies to the disputed Work Status Report, states in pertinent part "(b) If authorized under their licensing act, a treating doctor may delegate authority to complete, sign, and file a work status report to a licensed physician assistant or a licensed advanced practice registered nurse as authorized under Texas Labor Code §408.025(a-1). The delegating treating doctor is responsible for the acts of the physician assistant and the advanced practice registered nurse under this subsection…

   > (e) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:
   >
   > (1) after the initial examination of the injured employee, regardless of the injured employee's work status;
   > (2) when the injured employee experiences a change in work status or a substantial change in activity restrictions…
   >
   > (J)… The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section... Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   A review of the medical records submitted does not support that there was a substantial change in the injured employee's work status or in their activity restrictions. The documentation submitted does not support that the Work Status Report was filed upon an initial examination of the employee, as the office visit billed on the same date of service was for evaluation and management of an established patient. DWC finds no evidence that the Work Status Report was requested by the carrier or the employer.

   DWC finds that the requestor is not entitled to reimbursement for CPT code 99080-73.

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 requestor has established that reimbursement is due in the amount of $152.76.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for some of the disputed services. It is ordered that AIU Insurance Co. must remit to Rio Occupational Institute $152.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 20, 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.