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
Peak Integrated Healthcare

Respondent Name
Dakota Truck Underwriters

MFDR Tracking Number
M4-25-1646-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
March 24, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 7, 2025	99213	$7.90	$7.90
January 7, 2025	99080-73	$15.00	$0.00
	Total	$22.90	$7.90

Requestor's Position

"This bill was denied full payment to include the office visit for which all documentation has been provided, stating denial reason 'workers compensation jurisdictional fee adjustment.' The patient is entitled to reasonable medical care as stipulated in Texas law as related to the original injury. Office visits are recommended as determined to be medically necessary."
Amount in Dispute: $22.90

Respondent's Position

"In reviewing the dispute, the carrier determined that the bill was correctly audited, and so stands by the initial audit."

Response Submitted by: Stone Loughlin & Swanson, LLP

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. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports.

Denial Reasons

The insurance carrier reduced the payment for the disputed service with the following claim adjustment codes:

- 190-Billing for report and/or record review exceeds reasonableness.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- W3-Bill is a reconsideration or appeal.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005-No additional reimbursement allowed after review of appeal/reconsideration.
- P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What rules apply to the disputed services?
2. Is the requestor entitled to additional reimbursement for CPT Code 99213?
3. Is the requestor entitled to reimbursement for CPT Code 99080-73?

Findings

1. The requestor seeks additional reimbursement for an office visit, billed under CPT code 99213, and provided on January 7, 2025. 28 TAC §134.203 applies to the disputed service.

   28 TAC §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."

The requestor also seeks reimbursement for a works status report, billed under CPT code 99080-73, and provided on January 7, 2025. 28 TAC §129.5 applies to the dispute service.

28 TAC §129.5(e) states "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; and (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistants, or delegated advanced practice registered nurse's scheduled appointments with the injured employee."

2. The requestor is seeking additional reimbursement in the amount of $7.90 for CPT Code 99213 rendered on January 7, 2025. The division will calculate the MAR amount to determine fi the requestor is entitled to an additional payment.
    - The CPT code description for 99213 is, "A medical evaluation and management (E/M) service provided by physicians. This code is used to document and bill for a level three office visit, which involves a face-to-face encounter with the patient for the evaluation and treatment of a new or existing problem."

3. 28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

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

    - Date of service(s) in dispute: January 7, 2025
    - The 2025 DWC conversion factor is 70.18
    - The 2025 Medicare conversion factor is 32.3465
    - The disputed services were rendered in zip code 75043, the Medicare locality is 04412, Dallas."
    - The Medicare Participating amount for CPT code 99213 at this locality is $89.32.
    - Using the above formula, the DWC finds the MAR is $193.79.
    - The requestor seeks $193.79.
    - The respondent paid $185.89.
    - Reimbursement of $7.90 is recommended.

    The DWC finds that the requestor is entitled to an additional payment of $7.90. This amount is recommended.

4. The requestor seeks reimbursement in the amount of $15.00 for CPT code 99080-73 rendered on January 7, 2025.

   28 TAC §129.5(e) states "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; and (3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee."

   A review of the submitted documentation finds the following:

   - The DWC 73 rendered on January 7, 2025, did not meet the documentation requirements outlined in 28 TAC §129.5.
   - The DWC finds that the requestor is therefore not entitled to further 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.

The DWC finds the requester has established that reimbursement of $7.90 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 respondent must remit to the requestor $7.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 24, 2025
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 electronico CompConnection@tdi.texas.gov.