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
INTEGRITY HEALTH CLINIC

Respondent Name
TX ASSOCIATION OF COUNTIES RMP

MFDR Tracking Number
M4-22-1295-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 16, 2021	99204, 90471 and 90715	$161.89	$29.14
	Total	$161.89	$29.14

Requestor's Position

"According to the labor code and fee guidelines, a fair and reasonable amount was billed. Payments we receive from Sedgwick are below other comparable workers' compensation insurance companies we deal with regularly. We believe the amount billed reflects a reasonable fee for the quality of medical care provided, ensuring injured employees returned to work timely."

Amount in Dispute: $161.89

Respondent's Position

"Kevin Scully, PA-C provided the treatment at issue in this case. TAC RMP properly reimbursed Integrity Health Clinic at eighty percent of the relevant charges, This was consistent with the applicable fee guideline Medicare payment policies. Therefore, TAC RMP appropriately reimbursed Integrity Health Clinic for the services provided by a physician assistant."

Response Submitted by: Bruns, Anderson Jury & Brenner, L.L.P.

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.

Denial Reasons

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

- 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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 56 – Significant, separately identifiable E/M service rendered.
- N600 - Adjusted based on the applicable fee schedule for the region in which the service was rendered.

Issues

1. Is the Requestor entitled to additional reimbursement?
2. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 90715?
3. Is the requestor entitled to additional reimbursement for CPT Code 99204 and 90471?

Findings

1. The requestor seeks additional reimbursement for CPT Codes 99204, 90471 and 90715 rendered on December 16, 2021. The insurance carrier issued a partial payment and denied the remaining charge with denial reason codes, indicated above, (description provided above.)

   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."

   CPT code 99204 is defined as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

CPT code 90471 is defined as, "Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)."

CPT code 90715 is defined as, "Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use."

2. The requestor seeks additional reimbursement for CPT Code 90715.

   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."

   Review of the CMS Fee Schedule finds that CPT Code 90715 contains a status code E. Status Code E indicates, "Excluded form Physician Fee Schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures."

   The DWC finds that CPT Code 90715 is not eligible for reimbursement. As a result, $0.00 is recommended.

3. The requestor seeks additional reimbursement for an office visit, CPT Code 99204 and 90471 rendered by a physician's assistant (PA). The insurance carrier issued a payment in the amount of $200.00, for CPT Code 99204 and $24.54 for CPT Code 90471. The DWC finds that the insurance carrier's reduction of payment is based on Medicare's non-physician reimbursement policies. The DWC will now consider if the 80% reduction applies to PA's.

   Sec. 1451.104 NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT; EXCEPTION states,

   > (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.

   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. There is a separate payment policy for paying for PA assistant-at-surgery services. See section 110.2 of this chapter."

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 2021 DWC Conversion Factor is 61.17
- The 2021 Medicare Conversion Factor is 34.8931
- Per the medical bills, the services were rendered in Tyler, TX; therefore, the Medicare locality is "Rest of Texas."

The Medicare Participating amount for CPT code(s) 99204 at this locality is $163.39.

- 80% of the CMS Fee Schedule = Medicare Participating amount of $130.71.
- Using the above formula, the DWC finds the MAR is $229.14.
- The respondent paid $200.00.
- Reimbursement of $29.14 is therefore recommended.

The Medicare Participating amount for CPT code(s) 90471 at this locality is $16.47.

- 80% of the CMS Fee Schedule = Medicare Participating amount of $13.18.
- Using the above formula, the DWC finds the MAR is $23.11.
- The respondent paid $24.54.
- Reimbursement of $0.00 is therefore recommended.

4. The DWC finds that the requestor is therefore entitled to an additional payment amount of $29.14. 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 requester has established that reimbursement of $29.14 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 $29.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		April 5, 2022
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.