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

General Information

Requestor Name
UMC Physician Network

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-23-2084-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
April 26, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
08/25/2022	99203-25	$185.00	$167.28
08/25/2022	99080-73	$15.00	$15.00
08/25/2022	72100-TC	$60.00	$43.89
08/25/2022	J1885	$24.00	$1.00
08/25/2022	96372	$60.00	$21.51
	Total	$344.00	$248.68

Requestor's Position

"The service provided on 08/25/2022 denied, "The time limit for filing has expired". On 11/14/2022, the bill was submitted from UMC Physicians to Change Healthcare. On 11/14/2022, the payer first acknowledged the bill with no rejections. We obtained a letter from Change Healthcare providing proof that submission of bill was on 11/14/2022… "
Amount in Dispute: $344.00

Respondent's Position

"… Texas Mutual on 1/18/2023 received the bill from UMC PHYSICIANS (Attachment). The EDI bill submission does not match with the disputed amount submitted by the requestor… the EDI transmission does show DOS 11/14/2022, total charges is $185.00. The facility is disputing a billed charge of $344.00 and is not consistent with the EDI bill submission provided… Rule 133.20(b) states, 'Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided…' The rationale given by the requestor and discrepancy billed charge on the EDI bill transmission is not consistent with the Rule above. Our position is that no payment is due."
Response Submitted by: Texas Mutual Insurance Co.

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 Medical Fee Dispute Resolution requests.
2. 28 TAC §133.20 sets out requirements of medical bill submission by health care providers.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.
4. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and nurse practitioners.

Denial Reasons

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

- 29 – The time limit for filing has expired.
- 731 – Per 133.20 (B), providers must submit bills to payers within 95 days of the date of service.
- 131 – Claim specific negotiated discount.
- A16 – The reimbursement for healthcare services are subject to Workwell, TX Contracts, a certified WC HCN
- W3 – In accordance with TDI-DWC Rule 134.604, this bill has been identified as a request for reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. Has UMC Physician Network waived their right to medical fee dispute resolution (MFDR)?
2. How are the disputed services rendered by a nurse practitioner (NP) reimbursed under the Texas Workers' Compensation system?
3. Is UMC Physician Network entitled to reimbursement for disputed date of services August 25, 2022?

Findings

1. The requestor is seeking $344.00 for disputed date of services rendered August 25, 2022. (*Note that the date of service has been corrected in table above as it was entered incorrectly on DWC060 request form as 8/25/2023)

28 Texas Administrative Code §133.20 sets out requirements of timely medical bill submission, states in pertinent part "(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied."

Texas Labor Code §408.0272(b) sets out certain exceptions for untimely submission of a claim, states "(b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured; (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider."

Per documentation submitted, the division finds that the medical bill in dispute was successfully transmitted and accepted by the insurance carrier on November 14, 2022, less than 95 days after the disputed date of service, August 25, 2022.

Based on the submitted documentation, the Division finds that UMC Physician Network has not waived their right to medical fee dispute.

2. The services in dispute, rendered on August 25, 2022, were provided by a nurse practitioner.

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 nurse practitioners at a different amount than physicians.

Chapter 12 of the Medicare Claims Processing Manual states, "120 - Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services Payment Methodology (Rev. 2656, Issuance: 02-07-13, Effective: 02-19-13, Implementation: 02-19-13) See chapter 15, sections 200 and 210 of the Medicare Benefit Policy Manual, pub. 100- 02, for coverage policy for NP and CNS services. A.) General Payment: In general, NPs and CNSs are paid for covered services 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 NP 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 health care services at the Medicare rate plus a DWC multiplier. Reimbursing a NP at 80 percent of the actual charge is not the same methodology used for physician reimbursement and is contrary to TIC 1451.04(c).

28 TAC §134.203 Medical Fee Guideline for Professional Services, states in pertinent part:
(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.
The DWC finds that the requestor is therefore entitled to the lesser of the provider's usual customary charges or 85% of the Medicare Physician Fee Schedule.

3. The requester seeks reimbursement in the amount of $344.00 for disputed services rendered on August 25, 2022.

As finding #1 above indicates, documentation submitted supports the timely filing of the medical bill in dispute. Therefore, the division finds that UMC Physician Network is entitled to reimbursement.

The division finds that 28 TAC §134.203 applies to reimbursement of disputed services submitted in this MFDR request.

28 TAC §134.203 states in pertinent part, "(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. (2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) - (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas). (c) 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 = Maximum Allowable Reimbursement (MAR).

- Dates of service were rendered in 2022
- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per medical bills, the services were rendered in zip code 79404; the Medicare locality is 99.

- The Medicare Participating amount for CPT code 99203 at this locality is $109.04.
- 85% of the CMS Fee Schedule = $92.68
- Using the above formula, the division finds the MAR is $167.28
- The requester billed $185.00, and the respondent paid $0.00.
- The requestor is due $167.28 for CPT code 99203.

- The Medicare Participating amount for CPT code 72100-TC at this locality is $28.62.
- 85% of the CMS Fee Schedule = $24.33
- Using the above formula, the division finds the MAR is $43.89.
- The requester billed $60.00, and the respondent paid $0.00.
- The requestor is due $43.91 for CPT code 72100-TC.

- The Medicare Participating amount for CPT code 96372 at this locality is $14.02.
- 85% of the CMS Fee Schedule = $11.92
- Using the above formula, the division finds the MAR is $21.51.
- The requester billed $60.00, and the respondent paid $0.00.
- The requestor is due $21.51 for CPT code 96372.

Requester is seeking reimbursement for disputed code J1885. This code has no published Medicare rate per fee schedule. The division finds that TAC §134.203(d) applies to code J1885, states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; *(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule,* durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The Texas Medicaid published fee for code J1885 on disputed date of service August 25, 2022, is $0.40 per unit. Fifty cents per unit is 125 percent of the Medicaid published rate.

Provider billed 2 units of J1885. MAR for 2 units of disputed code J1885 is $1.00. Therefore, the requester is due $1.00 for code J1885.

Requester is seeking reimbursement for CPT Code 99080-73 rendered on August 25, 2022.

28 TAC §129.5 applies to CPT code 99080-73:
28 TAC §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. 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 are not required to submit a copy of the report being billed for with the bill if the report was previously provided. 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."

28 TAC §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

Review of submitted documentation finds that reimbursement of 99080-73 in the amount of $15.00 is supported in accordance with 28 TAC §129.5.

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 Division finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed date of service August 25, 2022. It is ordered that the Respondent, Texas Mutual Insurance Co., must remit to the Requestor, UMC Physician Network, $248.68 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature:

		May 19, 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 electronico CompConnection@tdi.tas.gov.