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

General Information

Requestor Name
Ashley Ferguson

Respondent Name
Hartford Insurance Co. of Midwest

MFDR Tracking Number
M4-23-2533-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
May 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
06-06-2023	99214	$55.00	$32.35
06-06-2023	99080	$15.00	$15.00
10-20-2022	99213	$27.00	$27.00
	Total	$97.00	$74.35

Requestor's Position

Regarding 06/06/2022: "… When the claim was processed, CPT code 99214 was only reimbursed $160.00. This amount was less than the agreed upon amount for Texas Worker's Comp… According to the Division of Texas Worker's Comp, the carrier is supposed to reimburse, 'provider agrees to accept as payment in full for Covered Services rendered to Participant the lesser of the Provider's actual billed charges or 180% of Texas Medicare allowable.' This was not done by the carrier when reimbursing for CPT code 99214… Furthermore, Texas workers compensation passed a bill, effective 09/01/2019, stating that nurse practitioners now had the ability to bill for the DWC 73 report, or work status report. According to Texas legislation under House Bill 387 under the labor code 408.025, "A treating doctor may delegate to an advanced practice registered nurse who is licensed to practice in this state under Chapter 301, Occupations Code..."

Regarding10-20-2022: "… CPT code 99213 was only reimbursed $108.00. This amount was less than the agreed upon amount for Texas Worker's Comp… According to the Division of Texas Worker's Comp, the carrier is supposed to reimburse, 'provider agrees to accept as payment in full for Covered Services rendered to Participant the lesser of the Provider's actual billed charges or 180% of Texas Medicare allowable.' This was not done by the carrier when reimbursing for CPT code 99213… "
Amount in Dispute: $97.00

Respondent's Position

"….We reviewed the bills and documentation submitted for the above claim dates of service and find that the original bills… were processed correctly in the total amount of $268.00. It was processed and paid based on the value for services performed by a licensed non-physician practitioner, These were processed correctly as it was a nurse practitioner performing the services…"

Response Submitted by: The Hartford Financial Services Group, Inc.

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. Texas Labor Code §413.011 sets out reimbursement policies and guidelines for workers' compensation medical services
2. Texas Labor Code §408.025 allows for an advanced practice registered nurse to complete and sign DWC Work Status Reports.
3. 28 Texas Administrative Code (TAC) §129.5 sets out the fee guidelines for the DWC73 reports.
4. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
5. 28 TAC §134.203 sets out the fee guideline for professional medical services.
6. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and nurse practitioners.

Denial Reasons

The insurance carrier (IC) reduced 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.
- 190 – Billing for report and /or record review exceeds reasonableness.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

Issues

1. How are the disputed services reimbursed under the Texas Workers' Compensation system?
2. Is the requestor entitled to additional reimbursement for disputed date of service June 6, 2022?
3. Is the requester entitled to additional reimbursement for disputed date of service October 20, 2022?

Findings

1. The services in dispute involve evaluation and management office visits, CPT code 99214 rendered on June 6, 2022, and CPT code 99213 rendered on October 20, 2022. Both services in dispute were rendered by a nurse practitioner (NP). The insurance carrier issued a partial payment and denied the remaining charges with denial reason code 252, defined above.

   The IC issued a payment in the amount of $160.00 for CPT code 99214.

   The IC issued payment in the amount of $108.00 for CPT code 99213.

   The payments issued were 80% of the billed amount in both cases. The insurance carrier's reduction of payment is based on Medicare's non-physician reimbursement policies. The division will now consider if 80% of the billed amount reimbursement applies to NP's.

   Texas Labor Code (TLC), Chapter 413 sets out the rights and responsibilities related to medical dispute resolution.

   TLC 413.011, states in part,

   > (c) This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 1451.104, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commissioner shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle. (d) Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

   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.

28 TAC §134.203 Medical Fee Guideline for Professional Services, 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) Maximum allowable reimbursement (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, "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 code 99214 and for code 99213 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). The 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.

The requester also billed $15.00 for service code 99080-73 on the same disputed date of service, June 6, 2022. 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."

28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

The DWC finds that 28 TAC §129.5 applies to the reimbursement of service Code 99080-73. 28 TAC §129.5 sets out the fee guidelines for the DWC73 reports 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."

The Work Status report was completed and signed by a NP provider. Texas Labor Code §408.025 allows for an advanced practice registered nurse to complete and sign DWC Work Status Reports, states in pertinent part, "(a-1) A treating doctor may delegate to a physician assistant who is licensed to practice in this state under Chapter 204, Occupations Code, or an advanced practice registered nurse who is licensed to practice in this state under Chapter 301, Occupations Code, the authority to complete and sign a work status report regarding an injured employee's ability to return to work. The delegating treating doctor is responsible for the acts of the physician assistant or advanced practice registered nurse under this subsection… "

2. The requester is seeking additional reimbursement for CPT codes 99214 and 99080-73 rendered on June 6, 2022, by a NP provider.

The division finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99214.

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 = MAR

- The 2022 DWC Conversion Factor is 62.46
- The 2022 Medicare Conversion Factor is 34.6062
- Per the medical bill, the services were rendered in zip code 78666; the Medicare locality

is 99, "Rest of Texas."

- The Medicare Participating amount for CPT code 99214 at this locality in 2022 is $125.38.
- 85% of the CMS Fee Schedule for 99214 = Medicare Participating amount of $106.57.
- Using the above formula, the DWC finds the MAR for 99214 = $106.57 x 1.804878895 = $192.35.
- Reimbursement shall be "the least of" the MAR or the provider's usual / customary charge in accordance with TAC §134.203(h).
- The requester billed $200.00 for CPT code 99214. The MAR of $192.35 is "the least of".
- Insurance Carrier paid $160.00 for CPT code 99214; $192.35 – $160.00 = $32.35.
- Additional reimbursement of $32.35 for CPT code 99214 is therefore recommended.

On the disputed date of service, the requester billed $15.00 for completion of a work status report under CPT code 99080-73. As previously stated above, the division finds that that 28 TAC §129.5 applies to the reimbursement of service Code 99080-73.

A review of the submitted DWC-73 Work Status report rendered on June 6, 2022, finds that the provider met documentation requirements in accordance with 28 TAC §129.5.

The division finds that the requester is entitled to reimbursement in the amount of $15.00 for CPT code 99080-73 rendered on June 6, 2022.

3. The requester is seeking additional reimbursement for CPT code 99213 rendered on October 20, 2022, by a NP.

   The division finds that 28 TAC §134.203, quoted above in finding #2, applies to the reimbursement of CPT codes 99213.

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

   - The 2022 DWC Conversion Factor is 62.46
   - The 2022 Medicare Conversion Factor is 34.6062
   - Per the medical bill, the services were rendered in zip code 78666; the Medicare locality is 99, "Rest of Texas."
   - The Medicare Participating amount for CPT code 99213 at this locality in 2022 is $88.65.
   - 85% of the CMS Fee Schedule for 99213 = Medicare Participating amount of $75.35.
   - Using the above formula, the DWC finds the MAR for 99213 = $75.35 x 1.804878895 = $136.00.
   - Reimbursement shall be "the least of" the MAR or the provider's usual / customary charge in accordance with TAC §134.203(h).
   - The requester billed $135.00 for CPT code 99213. The billed amount of $135.00 is "the least of".
   - Insurance Carrier paid $108.00 for CPT code 99213; $135.00 - $108.00 = $27.00.
   - Additional reimbursement of $27.00 for CPT code 99213 is therefore 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 division finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed dates of service. It is ordered that the Respondent, Hartford Insurance Co. of Midwest, must remit to the Requestor, Ashley Ferguson, $74.35 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 16, 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 managing 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 premiere 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.