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

General Information

Requestor Name
Kyle Jones, M.D.

Respondent Name
Znat Insurance Co.

MFDR Tracking Number
M4-24-0965-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
January 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 12, 2023	99203-25	$208.07	$176.94
	Total	$208.07	$176.94

Requestor's Position

"An E/M service was necessary to not only assess the [injury], but to examine his [medical condition] and to rule out a [diagnosis]. Modifier – 25 was appended to CPT 99203 to separate it from the [medical procedure] ... We are requesting payment of the E/M service for $208.07 and believe we have well-documented the need for it."
Amount in Dispute: $208.07

Respondent's Position

"The injured worker was seen on 10/12/2023 for a simple repair of [injury to body part] (12001). The disputed code 99203-25… was billed in combination with CPT code 12001… that has a global period '000 days.'… The submitted documentation does not present a significant and separately identifiable E/M service unrelated to the [injury to body part]. E/M work does not go above and beyond the work associated with the minor surgical procedure 12001. Therefore, the E/M service (CPT 99203) would be considered included in the payment for CPT code 12001 as a 'new' patient visit does not justify reporting an E/M service… No additional payment is due to the provider for disputed code 99203-25."

Response Submitted by: Zenith Insurance

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §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. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and nurse practitioners.
3. 28 TAC §134.203 sets fee guidelines for professional medical services.

Denial Reasons

- 97 - THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 - THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OR ANOTHER PROCEDURE PERFORMED ON THIS DATE.
- W3 - IN ACCORDANCE WITH TDI-DWC RULE 134 804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- Denial Reason Note: 99203 inclusive to 12001

Issues

1. Does the medical documentation support a separately identifiable service which justifies the use of modifier-25?
2. How are professional medical services that are provided by nurse practitioners reimbursed under the Texas Workers' Compensation system?
3. Is the requestor entitled to reimbursement for CPT code 99203-25?

Findings

1. The requestor is seeking reimbursement for the disputed evaluation and management (E/M) service, CPT code 99203-25, rendered by a nurse practitioner on October 12, 2023. On the same date of service, the same health care provider rendered and billed for CPT code 12001 plus other codes related to the performance of the procedure, 12001.

   The insurance carrier allowed payment of CPT code 12001 and denied payment of CPT code 99203-25, stating that 99203 is inclusive to the payment of CPT code 12001.

CPT Code 99203 is defined as, "Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter." The requestor appended modifier 25 to CPT code 99203, which indicates a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.

CPT code 12001 is described as, "Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet)." CPT code 12001 has a global period of "000" per Medicare.

CHAPTER III SURGERY: INTEGUMENTARY SYSTEM CPT CODES 10000-19999 FOR MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply."

A review of the medical record submitted finds that in addition to the performance of the minor surgical procedure represented by CPT 12001, the healthcare provider performed a separate neurological examination and ordered medical testing of a separate body part other than the body part to which procedure code 12001 was applied. The provider also rendered a diagnosis regarding a separate body part other than the body part to which CPT 12001 was applied.

DWC finds that the medical documentation submitted supports a separate identifiable evaluation and management service that justifies the use of modifier -25.

2. The service in dispute was rendered by a nurse practitioner (non-physician provider).

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) 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 an E/M CPT code at the Medicare rate plus a DWC multiplier.

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 for services rendered by a nurse practitioner.

3. The requestor is seeking reimbursement in the amount of $208.07 for CPT code 99203-25 rendered on October 12, 2023 by a Nurse Practitioner provider. Because the use of CPT code 99203-25 was found to be justified in finding number one, DWC finds that the requestor is entitled to reimbursement.

DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99203, which states in pertinent part, "(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... (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.

- Allowable fees are published by carrier and locality.
- Disputed service was rendered in zip code 75462, locality 99, Rest of Texas.
- The disputed date of service is October 12, 2023.
- The Medicare participating amount for CPT code 99203 in 2023 at this locality is $108.81.
- 85% of the CMS Fee Schedule (allowed for NP) = Medicare Participating amount of $92.49
- The 2023 DWC Conversion Factor is 64.83
- The 2023 Medicare Conversion Factor is 33.8872
- Using the above formula, the DWC finds the MAR is $176.94.
- The insurance carrier paid $0.00.
- Reimbursement in the amount of $176.94 is recommended for the disputed service of CPT code 99203-25 rendered by a nurse practitioner on October 12, 2023.

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 additional reimbursement is due in the amount of $176.94.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed service.

It is ordered that the Respondent, Znat Insurance Co., must remit to the Requestor, Kyle Elliott Jones, M.D., $176.94 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	January 29, 2024 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.