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

General Information

Requestor Name
Occupational Medicine Services

Respondent Name
Hartford Insurance Co. of Illinois

MFDR Tracking Number
M4-25-1342-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
February 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 3, 2025	99213	$6.50	$6.50
	Total	$6.50	$6.50

Requestor's Position

"CPT 99213 was charged for his visit according to the 2025 price. The EOB said, "The charge for this procedure exceeds the fee schedule allowance." A reconsideration was sent on 1/21/25 pointing out that the TDI-DWC multiplier and Medicare pricing for this code increased in 2025. The carrier denied this on 1/24/25, with the EOB stating "Original payment decision is being maintained." We believe we have coded correctly in accordance with the TDI rules and are entitled to the remaining $6.50."

Amount in Dispute: $6.50

Respondent's Position

"After further review of the documentation submitted with this dispute, there is no additional amount warranted. The original bill for dos 1/3/25 was received on 1/6/25 under control number ... and paid per fee schedule in the amount of $152.75 for CPT 99213.

Response Submitted by: The Hartford

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. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
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.

Adjustment Reasons

The insurance carrier 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.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – BILL IS A RECONSIDERATION OR APPEAL.
- 193 & 1115 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 2005 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.

Issues

1. How are the disputed services reimbursed under the Texas Workers' Compensation system?
2. Is the Requestor entitled to additional reimbursement for CPT code 99213 rendered on January 3, 2025?

Findings

1. The insurance carrier reduced payment for CPT code 99213 rendered by a nurse practitioner (NP) on January 3, 2025, with reason codes 252 and P12, defined above.

   The health care provider billed for CPT code 99213 rendered on the disputed date of service. The insurance carrier issued a reduced payment in the amount of $152.75 for CPT code 99213. The insurance carrier's reduction of payment is based on Medicare's non-physician reimbursement policies.

   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) 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 CPT 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). 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.

2. The requestor is seeking additional reimbursement in the amount of $6.50 for CPT code 99213 rendered on January 3, 2025. The disputed service is described as an outpatient office visit for the evaluation and management of an established patient.

DWC finds that 28 TAC §134.203 applies to the reimbursement of CPT code 99213.

28 TAC §134.203 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.

- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Per the medical bill, the services were rendered in zip code 75401; therefore, the Medicare locality is 99, "Rest of Texas."
- The Medicare Participating amount for CPT code 99213 at this locality in 2025 is $86.34.
- 85% of the CMS Fee Schedule for 99213 = Medicare Participating amount of $73.40.

- Using the above formula, DWC finds the MAR for 99213 rendered by a nurse practitioner in 2025 at this locality = $159.25
- The insurance Carrier paid $152.75 for CPT code 99213 on the disputed date of service; $159.25 - $152.75 = $6.50.
- Additional reimbursement in the amount of $6.50 is therefore recommended for the disputed CPT code 99213, rendered on January 3, 2025, by an NP.

DWC finds that additional reimbursement in the amount of $6.50 is due.

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 in the amount of $6.50 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 Illinois, must remit to the Requestor, Occupational Medicine Services, $6.50 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 28, 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 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.