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

General Information

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Meridian Security Insurance Co.

MFDR Tracking Number
M4-25-1762-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
April 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 14, 2024	99213-25-93	$200.00	$152.76

Requestor's Position

Excerpt from reconsideration request dated September 24, 2024: "The consultation for … does not require preauthorization. The Date of Service being denied for payment is 6/14/24."

Amount in Dispute: $200.00

Respondent's Position

The Austin carrier representative for Meridian Security Insurance Co. is Downs Stanford. The representative was notified of this medical fee dispute on April 8, 2025. Per 28 Texas Administrative Code §133.307 (d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information. As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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 (TLC) §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 §137.100 sets out disability treatment guidelines.
4. 28 TAC, Chapter 19 sets out the requirements for utilization review.
5. 28 TAC §133.240 sets out guidelines of medical bill processing and auditing by insurance carriers.
6. 28 TAC §134.203 sets out the fee guideline for professional medical services.
7. Texas Insurance Code (TIC) 1451.104 allows for different reimbursement for medical doctors and nurse practitioners.

Adjustment Reasons

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

- D94 - PAYMENT OF FURTHER TREATMENT HAS BEEN SUSPENDED BASED ON THE RESULTS OF THE IME AND/OR PEER REVIEW.
- 790 - THIS CHARGE WAS REIMBURSED TN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- G15 - PRICING IS CALCULATED BASED ON THE MEDICAL PROFESSIONAL FEE SCHEDULE VALUE.
- J08 - PRICING HAS BEEN CALCULATED ACCORDING TO THE GUIDELINES FOR NON-PHYSICIAN PROVIDERS.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- Q01 - ADDITIONAL ALLOWANCE RECOMMENDED. THIS HAS BEEN RE-EVALUATED AND AN ADDITIONAL ALLOWANCE IS RECOMMENDED.
- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APEAL.

Issues

1. Is the insurance carrier's reason for denial of reimbursement supported?
2. How are the disputed services reimbursed under the Texas Workers' Compensation system?
3. Is the Requestor entitled to reimbursement for CPT code 99213 rendered on June 14, 2024?

Findings

1. This medical fee dispute involves non-payment of a professional medical service, the evaluation and management of an established patient billed under CPT code 99213, rendered on June 14, 2024.

   Per the submitted explanation of benefits (EOB), the insurance carrier denied the disputed service due to "Payment of further treatment has been suspended based on the results of an IME and/or peer review."

   A review of the submitted documentation finds no evidence of the IME or peer review referenced in the EOB denial reason.

   DWC Rule 28 TAC §137.100 (e) states, "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective utilization review is defined in 28 TAC §19.2003 (b)(31) as, "A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted."

   28 TAC §134.240 (q) states, in relevant part, "when the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title…, including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ..."

   28 TAC §133.307 (d)(2)(I) which sets out the procedures for medical fee dispute resolutions, states in pertinent part, "Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records: … (I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review)."

   A review of the submitted documentation finds no evidence that a utilization review was performed in accordance with the applicable DWC Rules and Labor Codes.

   DWC finds that the insurance carrier's reason for denial of the disputed service rendered on June 14, 2024, is not supported.

2. The professional medical service in dispute, CPT code 99213, was rendered by an advanced practice nurse or nurse practitioner (NP) on June 14, 2024.

   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.

3. The requestor is seeking reimbursement for CPT code 99213 rendered on June 14, 2024, by an advanced practice nurse (NP). The disputed service is described as an outpatient office visit for the evaluation and management of an established patient. The requestor appended the CPT code with modifier "93" which indicates "synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system."

   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 2024 DWC Conversion Factor is 67.81
   - The 2024B Medicare Conversion Factor is 33.2875
   - Per the medical bill, the services were rendered in zip code 78666; therefore, the Medicare locality is 99, "Rest of Texas."
   - The Medicare Participating amount for CPT code 99213 at this locality in June of 2024 is $88.22.
   - 85% of the CMS Fee Schedule for 99213 = Medicare Participating amount of $74.99.
   - Using the above formula, DWC finds the MAR for 99213 rendered by a nurse practitioner in June of 2024 at this locality = $152.76.
   - Reimbursement shall be "the least of" the MAR or the provider's usual customary charge in accordance with TAC §134.203(h).
   - The requestor billed $200.00 for CPT code 99213. The calculated MAR amount of $152.76 is "the least of".
   - Insurance Carrier paid $0.00 for CPT code 99213 on the disputed date of service;
   - Reimbursement in the amount of $152.76 is therefore recommended for the disputed CPT code 99213, rendered on June 14, 2024, by an NP.

   DWC finds that reimbursement in the amount of $152.76 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 reimbursement in the amount of $152.76 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, Meridian Security Insurance Co., must remit to the Requestor, Nueva Vida Behavioral Health, $152.76 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		June 25, 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.