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
M4-25-0862-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
December 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 6, 2024	Examination to Determine Maximum Medical Improvement – 99455-V5	$357.45	$357.45

Requestor's Position

"Per the new billing guidelines by TDI-DWC, CPT code 99455-V5 was billed to the carrier for $357.45 for the MMI portion. CPT code 99455 was billed for the IR exam, using ROM for one musculoskeletal body area, for $385. An EOB from the carrier was received paying only $385 and stating, 'Please resubmit with the correct V code '3' to reflect the documented EM level.' An appeal was sent on 11/16/24 to point out that our provider spent 55 minutes with … and documented this in the note. The carrier denied payment again with the EOB stating the same request for resubmission as a V3 visit and 'No additional payment is due.'

"We are requesting payment of the remaining balance of $357.45 and believe we have coded correctly and submitted all appropriate documentation for the amount charged."

Amount in Dispute: $357.45

Respondent's Position

"Zenith's review and findings associated with the disputed code 99455-V5 are as follows:

28 Texas Administrative Code §133.240 Medical Payments and Denials states,

'(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.'

"Based on the review of the provider's report the documentation supports a lower level of service.

- Number/Complexity of Problems Addressed: Moderate
- Amount/Complexity of Date Reviewed: Straightforward
- Risk of Complications/Morbidity/Mortality: Low

The level of visit billed 99455-V5 is not supported by the submitted documentation. The E/M level of service is being recommended at a more appropriate level. As of today, Zenith has not received a corrected billing from the provider. Therefore, no payment is due to the provider."

Response Submitted by: The Zenith

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) §133.10 sets out the completing a medical bill.
2. 28 TAC §133.210 sets out the requirements for medical documentation.
3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 TAC §134.203 sets out the fee guidelines for professional medical services.
5. 28 TAC §134.250 sets out the fee guidelines for examinations by treating doctors to determine maximum medical improvement (MMI) and impairment rating (IR).

Denial Reasons

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

- 205 – This charge was disallowed as additional information/definition is required to clarify service/supply rendered.

- 375 – Please see special *Note* below.
- 16 – Claim/service lacks information or has submission/billing error(s).
- M127 – Missing patient medical record for this service.
- MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim
- MA30 – Missing/incomplete/invalid type of bill.
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that info.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Note: "UPON FURTHER REVIEW, NO ADDITIONAL PAYMENT IS DUE."
- Note: "PLEASE RESUBMIT WITH THE CORRECT V CODE '3' TO REFLECT THE DOCUMENTED EM LEVEL."
- Note: "LINE 2 WAS PAID ON 8/26/24 CK# C165288"

Issues

1. Is the insurance carrier's denial of payment based on missing patient record supported?

2. Is the insurance carrier's denial of payment based on type of bill supported?

3. Is the insurance carrier's denial of payment based on submission or billing errors supported?

4. Is Kyle Jones, M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Jones is seeking reimbursement for the MMI portion of an examination to determine MMI and IR. The insurance carrier denied payment, in part, stating, "Missing patient medical record for this service."

   Per 28 TAC §133.210(b), "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents."

   28 TAC §134.250(a) states, in relevant part, that "The MMI or IR examination must include:" … "(4) the preparation and submission of reports …"

   DWC finds that the greater weight of evidence supports that a relevant report was submitted to the insurance carrier. The insurance carrier also stated, "This charge was disallowed as additional information/definition is required to clarify service/supply rendered," and "Additional information has been requested from the member. The charges will be reconsidered upon receipt of that info."

   28 TAC §133.210(d) states, "Any request by the insurance carrier for additional documentation to process a medical bill shall:

   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the

response;
(4) be relevant and necessary for the resolution of the bill;
(5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
(6) indicate the specific reason for which the insurance carrier is requesting the information; and
(7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation."

DWC found no evidence that the insurance carrier requested additional information in accordance with 28 TAC §133.210. Therefore, DWC finds that the insurance carrier has not supported a denial of payment based on missing patient record.

2. The insurance carrier also denied payment stating, "Missing/incomplete/invalid type of bill." The services in question are considered professional medical services. Therefore, these services are required to be billed on the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500), in accordance with 28 TAC §133.10.

   DWC finds that the requestor submitted the correct type of bill for the services in question. Therefore, this denial reason is not supported.

3. The insurance carrier also denied payment based on submission or billing errors. Explanations of benefits submitted to DWC included the additional note, "PLEASE RESUBMIT WITH THE CORRECT V CODE '3' TO REFLECT THE DOCUMENTED EM LEVEL."

   In its position statement, the insurance carrier stated, "Based on the review of the provider's report the documentation supports a lower level of service."

   The health care provider billed the MMI portion of the examination in question with procedure code 99455-V5. Per 28 TAC §134.250(c) states, in relevant part, "The following applies for billing and reimbursement of an MMI … evaluation by a treating doctor.

   (1) CPT code. The treating doctor must bill using CPT code 99455 with the appropriate modifier. Modifiers 'V3,' 'V4,' or 'V5' must be added to CPT code 99455 to correspond with the last digit of the applicable office visit.
   (2) MMI. MMI evaluations must be reimbursed based on the applicable established patient office visit level associated with the examination under §134.203 of this chapter."

   The applicable established patient office visit level associated with modifier "V5" is procedure code 99215. This code is defined as follows: "Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. **When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.**" [emphasis added]

   Chapter 6 of the AMA CPT Manual also states, "Code selection is based on MDM or total time, including face-to-face and non-face-to-face time spent on the date of the encounter … Total time for these services includes **total face-to-face and non-face-to-face time** personally

spent by the physician or other qualified health care professional on the day of the encounter." [emphasis added]

In the submitted narrative report, Dr. Jones stated, "55 minutes spent face to face with patient (interview, examination, discussion, counseling, reviewing medical records and x-rays, formulation of plan/assessment, researching AMA Guides, impairment calculations, and documentation of the encounter."

DWC finds that the level of service billed was supported by the documentation provided. Therefore, this denial reason was not supported.

4. Because the insurance carrier failed to support its denial of payment for the examination in question, DWC finds that Dr. Jones is entitled to reimbursement.

   28 TAC §134.203(c) states, in relevant part, "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, … 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 …"

   28 TAC §134.203(h) states, "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."

   To determine the MAR, the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Medicare Participating Amount.

   - The DWC conversion factor for 2024 is 67.81.
   - The Medicare conversion factor for 2024 is 33.2875.
   - Per the submitted medical bills, the service was rendered in zip code 75462 which is in Medicare locality 0441299.
   - The Medicare participating amount for CPT code 99215 is $175.54.

   The MAR is calculated as follows: (67.81/33.2875) x $175.54 = $357.59.

   The total MAR for disputed code 99455-V5 is $357.59. Dr. Jones is seeking $357.45. This amount is 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.

DWC finds the requestor has established that reimbursement of $357.45 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that ZNAT Insurance Co. must remit to Kyle Jones, M.D. $357.45 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 7, 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 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.