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

General Information

Requestor Name
Kyle E. Jones, M.D.

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-25-1276-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
February 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 30, 2024	Examination to Determine Maximum Medical Improvement – 99455-V5	$357.45	$357.45

Requestor's Position

"CPT code 99455-V5 was billed to the carrier for $357.45 for the MMI portion … We are requesting payment 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

"As seen in the original denial for DOS 10/30/2024 (-1), the carrier's bill review vendor indicated the documentation included for previously listed DOS did not meet the High Level MDM level as denfined by CPT/AMA.

"Per the AMA, effective 1/1/2021, a hight level of decision making should be documented to support 99245(V5). Upon receipt of the reconsideration requests for both dates of service, Corvel deemed that the documentation submitted for 99215 did not meet AMA criteria nor did the stated time of '45 minutes' appear to be documented …

"Requestor further documents that the DRE method was used to the Impairment Rating for the claimant's injury which was paid on line 2 at $192 (1 MSK area). **Note: Neither DRE nor ROM factor into reimbursement for IR as of 06/01/2024 when the new fees for MMI/IR/DD/RD/RME were updated …

"It is the Respondent's belief that the Requestor's documentation does not support modifier V5 simply because 1) the HCP indicates 45 minutes listed in the narrative, since the 45 minutes s/b documented and 2) the HCP determining MMI/IR does not mean the visit should automatically be billed as V5/99215. Documentation just doesnot support that level of service/decision making."

Response Submitted by: CorVel

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. 28 TAC §134.203 sets out the fee guidelines for professional services.

3. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by the treating doctor.

Denial Reasons

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

- 04P – Services unsubstantiated by documentation
- 4 – Procedure code inconsistent with modifier used
- 150 – Payment adjusted/unsupported service level
- Notes: "Neither a HIGH level of Medical Decision Making (MDM) or Time spent has been adequately documented in the patient record(2021 CPT). Please recode & resubmit or provide additional documentation"
- Notes: "Effective 6-1-24, modifiers RE and WP are no longer valid for use when billing for MMI/IR/DDE.

Issues

1. Is the insurance carrier's denial based on service level supported?

2. Is Kyle E. Jones, M.D. entitled to additional reimbursement?

Findings

1. Dr. Jones is seeking reimbursement for an examination to determine maximum medical improvement performed as the treating doctor. Dr. Jones billed the examination using procedure code 99455-V5.

   28 TAC §134.250(c) states, in relevant part, "The following applies for billing and reimbursement of an MMI or IR 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 as billed is 99215. This code is defined as, "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 … time alone may be used to select the appropriate level of service. **Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter.**" [emphasis added]

   In the narrative report provided in the dispute request, Dr. Jones stated, "*I personally spent a total of 45 minutes combined face to face with patient (interview, exam, counseling, discussing plan), reviewing medical records and referrals, counseling/discussion with patient and employer, researching the* AMA Guides to the Evaluation of Permanent Impairment, 4th Edition *and assessment of impairment rating, and documentation on this encounter*."

   DWC finds that the insurance carrier's denial of payment based on level of service is not supported.

2. Because the insurance carrier failed to support its denial of payment, DWC will review the service in question for reimbursement.

   Reimbursement policies for professional services is found in 28 TAC §134.203, which states, in relevant part: "(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."

Reimbursement fee guidelines for professional services are addressed in 28 TAC §134.203(c), which states in relevant part: "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(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 Participating Amount.

- The DWC conversion factor for 2024 is 67.81.
- The Medicare conversion factor for October 30, 2024, is 33.2875.
- Per the submitted medical bills, the service was rendered in zip code 75401 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 $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 Indemnity Insurance Co. of North America must remit to Kyle E. 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

		April 3, 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.