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

General Information

Requester Name
Ranil Ninala MD

Respondent Name
Travelers Casualty & Surety Company

MFDR Tracking Number
M4-25-2588-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
June 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2025	99205-25	$26.38	$0.00
April 28, 2025	95886	$19.28	$0.00
April 28, 2025	95909	$13.33	$0.00
	Total	$58.99	$0.00

Requester's Position

"The insurance carrier has not paid this claim in accordance with DWC Rules governing the specific services billed."

Amount in Dispute: $58.99

Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the disputed services. The Carrier has reviewed the documentation and contends the Provider has been appropriately reimbursed for the services at issue. The Carrier has reviewed the Maximum Allowable Reimbursement Calculation and contends the reimbursement is correct as calculated."

Response Submitted by: Travelers

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 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.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 56 – Significant, separately identifiable E/M service rendered.
- W3 – Bill is a reconsideration or appeal.
- 947 – Upheld no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Is the insurance carrier's denial supported?
2. Is the requester entitled to additional reimbursement?

Findings

1. This dispute pertains to the reduction of payment of medical services referred by a designated doctor rendered on April 28, 2025, and billed under CPT codes 99205-25, 95886 and 95909. The requester is seeking additional reimbursement in the amount of $58.99. Using the previously mentioned denial reduction codes, the insurance carrier audited and upheld the reduction decision.

   28 TAC §134.203(a)(5) states "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."

   28 TAC §134.203(b)(1) states "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."

The requester billed CPT Code 99205 is defined as, "Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter."

The requester appended modifier "25" described as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service, is used when distinct services are performed on the same day."

The requester billed CPT Code 95886 is defined as, "Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels."

The requester billed CPT Code 95909 is defined as, "Nerve conduction studies; 5-6 studies."

The disputed services are therefore reviewed pursuant to the applicable rules and guidelines.

2. 28 TAC §134.203(c)(1) states, "…To determine to MAR for professional services, system participants shall apply the Medicare payment policies with minimal modification…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 $53.68…"

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Medicare Payment = Maximum Allowable Reimbursement (MAR).

   - The 2025 DWC Conversion Factor is 70.18
   - The 2025 Medicare Conversion Factor is 32.3465
   - A review of the medical bills finds that the disputed services were rendered in zip code 78228; the Medicare locality is "Rest of Texas."
   - The Medicare Participating amount at this locality for CPT code 99205 is $209.99, CPT Code 95909 is $124.00, and CPT Code 95886 is $87.11.
   - Using the above formula, the DWC finds the MAR for CPT Code 99205 is $455.60, CPT Code 95909 is $269.03, and CPT Code 95886 is $377.99 for a total MAR of $1,102.62.
   - The respondent paid $1,102.63.

   The requester is not entitled to additional reimbursement for the services in dispute.

   The DWC finds that the requester is entitled to reimbursement for the disputed services. As a result, $0.00 is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		August 29, 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, 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 prefiere 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.