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

General Information

Requestor Name
Cesar Duclair MD

Respondent Name
LM Insurance Corp

Carrier's Austin Representative
Box Number 60

MFDR Tracking Number
M4-25-2938-01

DWC Date Received
July 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 12, 2025	99205 25	$481.98	$0.00
April 12, 2025	95886	$1.58	$0.00
April 12, 2025	95911	$3.70	$0.00
	Total	$487.94	$0.00

Requestor's Position

"The insurance carrier has not properly paid this claim in accordance with DWC Rules governing the specific service billed. ...SPECIFICE REASONING/RESPONSE: RATES SET BY TDI. 99205 RATE IS $481.98 INCORRECTLY REDUCED TO $0.00, 95886 RATE FOR 2 UNITS IS $397.28 INCORRECTLY REDUCED TO $395.70."

Amount in Dispute: $487.94

Respondent's Position

"The bill has been reviewed, and no additional payment is due. …The modifier 25 is not supported as the definition of modifier 25: 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. The code cannot be paid since the code on the bill 95911 has a global period of "XXX". …Codes 95911 and 95886 x 2 were paid per the TX FS.

Response submitted by: Liberty Mutual

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. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services..

Denial Reasons

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

- 5845 – No significant identifiable evaluation and management service has been documented.
- 309 - The charge for this procedure exceeds the fee schedule allowance.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is the insurance carrier's denial of code 99205 -25 supported?

2. What rule is applicable to reimbursement?

3. Is the requester entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $481.98 for CPT codes 99205-25, $1.58 for HCPCS code 95886 and $3.70 for HCPCS code 95911 rendered

on April 12, 2025. The insurance carrier denied the evaluation and management code 99205 for lack of documentation. DWC Rule 28 TAC §134.203(b)(1) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing' correct coding initiatives (CCI) edits; modifiers… DWC Rule 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."

The code 99205 is defined as, Office or other outpatient visit 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 total time on the date of the encounter for code selection, **60** minutes must be met or exceeded.

Review of the "EMG/NCV Consultation and Testing submitted with the request for MFDR found the total time was not indicated. The E/M Interactive Score Sheet at https://www.novitas-solutions.com/EMScoreSheet was used to determine the medical decision making was low. The requirements of code 99205 were not met. The insurance carrier's denial of code 99205 -25 based on documentation is supported.

2. DWC Rule 28 Texas Administrative Code §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…"

   The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

   (DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

   - Code 95886 has an allowable of $91.19 for location Dallas, TX.
     - 70.18/32.3465 x $91.19 x 2 = $395.70
     - Carrier paid $395.70
   - Code 95911 has an allowable of $202.79 for Dallas, TX.
     - 70.18/32.3465 x $202.79 = $439.98
     - Carrier paid $439.98

3. The total recommended reimbursement for the disputed services is $835.68. The insurance carrier paid $835.68. No additional payment 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 Peak Integrated Health Services has not established that additional reimbursement is due.

Order

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

Authorized Signature

_____	_____	September 5, 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 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.