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

General Information

Requester Name
Texas Tech University Health Center

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-26-0271-01

Carrier's Austin Representative
Box Number 45

DWC Date Received
September 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 23, 2025	99203	$230.00	$0.00
January 23, 2025	20550	$116.00	$116.00
January 23, 2025	J1100	$20.00	$0.60
	Total	$366.00	$116.60

Requester's Position

"Our bill has been denied stating 'provider [name of provider] is the one that rendered the services for this date of service.'

"[name of provider] is a resident in our teaching facility. He is not a licensed practicing physician; he has a learning permit. According to our medical records, Dr. Brendan Mackay 'saw and examined the patient.' He also 'discussed with the resident and agreed with the resident's findings' and was the one to perform the injection. Dr. Mackay was also the provider who signed the note along with the resident."

Amount in Dispute: $366.00

Respondent's Supplemental Position

"The Office reviewed the medical record and determined that the services were provided by a resident, who is a non-licensed provider billing under the teaching doctor. Review of Medicare policies, teaching physicians must identify residents assisting in patient care and services on a claim and must include modifier GC for each service that is provided unless the service is under the primary care exception. The GE modifier must be utilized for each service provided under the primary care exception (Exhibit B). The medical billing submitted by the requester did not include the modifiers identifying that the physician providing services was a resident assisting in patient care."

Response Submitted by: State Office of Risk Management

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- B20- PAYMENT ADJUSTED BECAUSE THE PROCEDURE/SERVICE WAS PARTIALLY OR FULLY FURNISHED BY ANOTHER PROVIDER.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- EOB Comment: PER MEDICAL RECORD PROVIDER […] IS THE ONE THAT RENDERED THE SERVICES FOR THIS DATE OF SERVICE.
- EOB Comment: PURSUANT TO RULE 133.20, PLEASE REBILL WITH THE RENDERING PHYSICIAN'S NAME IN BOX 31; ATTACHED REPORT IDENTIFIES SERVICES PERFORMED BY BENJAMIN MCINTOSH, MD.

Issues

1. What rules apply to the billing and reimbursement of the disputed services?
2. Is the Insurance Carrier's denial reason(s) of CPT code 99203 supported?
3. Is the Insurance Carrier's denial reason(s) of CPT codes 20550 and J1100 supported?
4. Is the Requester entitled to reimbursement?

Findings

1. This dispute involves professional medical services rendered on January 23, 2025. DWC finds that 28 TAC §134.203 which sets out the fee guideline for professional medical services, applies to the billing and reimbursement of the services in dispute.

   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."

2. A review of the medical bills submitted finds that on the disputed date of service, the requester charged $230.00 for the evaluation and management (E/M) of a new patient billed under CPT code 99203-25.

   A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier denied reimbursement for CPT code 99203 due to a provider, other than the provider indicated on the medical bill, furnished the service per the medical record.

   A review of the medical record submitted finds that on the disputed date of service, the E/M office visit was performed by a physician resident in training under the supervision of the physician indicated on the medical bill.

   As described in the Medicare MLN Booklet, Guidelines for Teaching Physicians, Interns & Residents, "Teaching physicians must identify residents assisting in patient care and services on claims… Claims must include the GC modifier on each service unless you provide the service under the primary care exception. You or another billing provider certify you meet these conditions. Teaching physicians must attest to their MAC that they meet the E/M Services Primary Care Exception section conditions… Claims must include the GE modifier on each service provided under the primary care exception."

   A review of the submitted medical bill finds that on the disputed date of service CPT code 99203 was not appended with either modifier "GC" nor modifier "GE" as required per Medicare reimbursement policy pertaining to teaching physicians and services provided by medical residents in training.

   DWC finds that the insurance carrier's denial reason of CPT code 99203, is supported. Therefore, reimbursement for CPT code 99203 rendered on January 23, 2025, by a medical resident in training, is not recommended.

3. A review of the medical bills submitted finds that on the disputed date of service, the requester charged $116.00 for one unit of procedure code 20550 and charged $20.00 for 4 units of procedure code J1100.

A review of the explanation of benefits (EOB) documents submitted finds that the insurance carrier denied reimbursement due to a provider, other than the provider indicated on the medical bill, furnished the service per the medical record.

Procedure code 20550 is described as "Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar 'fascia')."

Procedure code J1100 represents an injectable medication of 1 mg dexamethasone sodium phosphate.

A review of the medical record submitted finds that on the disputed date of service, the medical documentation supports that the procedure described by code 20550 was performed by the physician provider indicated on the medical bill, using 4 mg (4 units) of the injectable medication represented by procedure code J1100.

According to the medical documentation, the professional medical service of an injection as described by the procedure codes 20550 and J1100, was provided by the physician indicated on the medical bill, DWC finds that the insurance carrier's reason for denial is not supported. Therefore, the requester is entitled to reimbursement.

4. The requester is seeking reimbursement in the total amount of $366.00 for services rendered on January 23, 2025.

   Because the insurance carrier's denial reason for CPT code 99203 is supported, DWC finds the requester is not entitled to reimbursement for this procedure code.

   Because the insurance carrier's denial reason for CPT codes 20550 and J1100 is not supported, DWC finds that the requester is entitled to reimbursement for these two procedure codes.

   DWC finds that 28 TAC §134.203 applies to the reimbursement of the disputed procedure code 20550.

   28 TAC §134.203 states in pertinent 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. (2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) - (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas). (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. For Surgery when performed

in a facility setting, the established conversion factor to be applied is $66.32. (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.

- Date of service was rendered in 2025
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Per medical bills, the services were rendered in zip code 79430; the Medicare locality is 99.
- The Medicare Participating amount for CPT code 20550 in 2025 at this locality is $54.79.
- Using the above formula, DWC finds the MAR is $118.87.
- The requester billed $116.00, and the respondent paid $0.00.
- Reimbursement in the amount of $116.00 for CPT code 20550 is recommended.

The requester is seeking reimbursement for disputed procedure code J1100. This code has no published Medicare rate per fee schedule. DWC finds that TAC §134.203(d), which applies to procedure code J1100, states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

- The Texas Medicaid published fee for code J1100 on the disputed date of service January 23, 2025, is $0.12 per unit, this is the base rate.
- 125 percent of the Medicaid rate = $0.15 per unit.
- The requester billed 4 units of procedure code J1100. The MAR for 4 units of the disputed procedure code J1100 is $0.60.
- The insurance carrier paid $0.00 for this procedure code.
- Reimbursement in the amount of $0.60 is recommended for 4 units of procedure code J1100 rendered on January 23, 2025.

DWC finds that the requester is entitled to reimbursement in the total amount of $116.60 for the services in dispute rendered on January 23, 2025.

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.

DWC finds the requester has established that reimbursement is due in the amount of $116.60.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the services in dispute. It is ordered that State Office of Risk Management must remit to Texas Tech University Health Center $116.60 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		October 14, 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, 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.