



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Ranil Ninala MD

Respondent Name

Hartford Insurance Co of Illinois

MFDR Tracking Number

M4-26-0294-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

September 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 29, 2025	99205	\$481.98	\$0.00
April 29, 2025	95886	\$1.94	\$0.00
April 29, 2025	95909	\$3.35	\$0.00
Total		\$487.27	\$0.00

Requester's Position

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

Amount in Dispute: 487.27

Respondent's Position

"The original bill for dos 4/29/25 was received on 5/5/25 under control number 222548470 denied CPT Code 99205 with modifier 25 denied as furnished medical records not conclusive of the level of care provided. The other services paid per fee schedule."

Response submitted by:

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 reimbursement guidelines for professional medical services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 55 – The E/M service is warranted/reimbursable only when significant, identifiable and additional services are performed in conjunction with the service. Therefore, no reimbursement was made for the EM service as it is included in the service performed.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. What rule(s) are applicable to reimbursement?
2. Is the requester due additional reimbursement?

Findings

1. The requester is seeking reimbursement of Code 99205. The respondent states, "...denied as furnished medical records not conclusive of the level of care provided." DWC Rule 28 TAC §134.203 (b) states in pertinent part, for coding, billing, reporting, and reimbursement of

professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including is coding; billing; correct coding initiatives (CCI) edits.

- CPT 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."
- The American Medical Association (AMA) CPT Code and Guideline Changes, effective January 1, 2021, can be found at: <https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf>

An interactive E&M scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet. A review of the submitted medical documentation indicates.

- Low number and complexity of problems addressed.
- Moderate risk of complications and/or morbidity or mortality,
- Low risk of complications and/or morbidity or mortality of patient.

For these reasons, medical documentation submitted did not meet AMA criteria for reimbursement of CPT code 99205.

DWC finds that the insurance carrier's position is supported. No payment is recommended for code 99205 for date of service April 29, 2025.

The requester also indicates the reimbursement of codes 95886 and 95909 are due additional reimbursement. DWC Rule 28 TAC §134.203 (c)(1)(2), states in pertinent parts, (c) 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, 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....
- (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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.

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

$(\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment} = \text{MAR}$. In this instance,

- The DWC Conversion Factor for 2025 is 70.18
- The Medicare Conversion Factor for 2025 is 32.3465
- The Carrier/Location Physician Fee Schedule Allowable for Fort Worth is shown below
 - 95886 - $\$90.66 \times 70.18/32.3465 = \196.70 . The insurance carrier paid \$196.70. No payment is due.
 - 95909 - $\$128.60 \times 70.18/32.3465 = \279.01 . The insurance carrier paid \$279.01. No payment is due.

2. The requester submitted to MFDR for reimbursement of code 99205. Review of the information provided and the applicable DWC rules and fee guidelines, no reimbursement is recommended as the submitted code was not supported by the description of services reviewed and rendered. The requester submitted to MFDR for additional reimbursement of codes 95886 and 95909. Review of the applicable DWC rules and fee guidelines found the amount paid by the insurance carrier was at the Maximum Allowed Reimbursement (MAR). No additional payment is recommended.

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 not established that additional 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

Signature

Medical Fee Dispute Resolution Officer

October 20, 2025

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 electrónico CompConnection@tdi.texas.gov.