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

General Information

Requester Name
Ranil Ninala, M.D.

Respondent Name
Accident Fund Insurance Co.

MFDR Tracking Number
M4-26-0296-01

Carrier's Austin Representative
Box Number 6

DWC Date Received
September 30, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2025	99205	$262.36	$0.00
April 28, 2025	95886	$8.65	$0.00
April 28, 2025	95909	$5.65	$0.00
	Total	$49.36[sic]	$0.00

Requester's Position

"CARRIER PARTIALLY PAID THE BILL AND HAS NOT RESPONDED TO THE RECONSIDERATION."

Amount in Dispute: $49.36 per DWC060; $276.66 per corrected calculations of line-item amounts in dispute.

Respondent's Position

"Based on review, it was determined that payment was appropriate based on the Texas Fee Schedule effective 4/1/2025 for region 99 based on zip code 78228 where the services were performed.

99205- fee schedule allowed amount is $455.60
95909- fee schedule allowed amount is $269.03
95886- fee schedule allowed amount is $188.99

"Please see the attached copy of the EOR processed for these exact amounts. Accident Fund does not agree that any additional amount is owed to the provider."

Response Submitted by: Stone, Laughlin & Swanson, LLP

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.
3. 28 TAC §133.210 sets out medical documentation requirements for reimbursement of medical services.

Adjustment Reasons

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

- P12 – Workers' Compensation jurisdictional fee schedule adjustment.
- 01(P12) – the charge for the procedure exceeds the fee schedule amount.

Issues

1. What rules apply to the disputed services?
2. Is the requester entitled to additional reimbursement for CPT Code 99205-25?
3. Is the requester entitled to additional reimbursement for CPT code 95886?
4. Is the requester entitled to additional reimbursement for CPT code 95909?

Findings

1. The dispute concerns an evaluation and management service (E/M) billed under CPT code 99205-25 as well as electromyography and nerve conduction studies billed under CPT codes 95886 and 95909, respectively.

   DWC finds that 28 TAC §133.210(c)(1) applies to the documentation requirements of CPT code 99205. 28 TAC §133.210(c)(1) sets out medical documentation requirements, stating in pertinent part "In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: the two highest Evaluation and Management (E/M) office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes…"

   As CPT code 99205 is one of the two highest E/M codes, DWC finds that (TAC) §133.210(c)(1)

required the requester to submit supporting documentation to satisfy American Medical Association requirements.

DWC finds that 28 TAC §134.203(b)(1) 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. According to the submitted DWC060 Medical Fee Dispute Resolution (MFDR) Request form, the requester is seeking additional reimbursement in the amount of $262.36 for CPT Code 99205-25.

   - 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 (MDM). When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter."
   - 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/2019-06/cpt-office-prolonged-svs-code-changes.pdf. In summary, CPT 99205 documentation must contain two out of three of the following elements: 1) high level of number and complexity of problems addressed 2) extensive level of amount and/or complexity of data to be reviewed and analyzed 3) high risk of morbidity/mortality of patient management OR must document 60-74 minutes of total time spent on the date of patient encounter.
   - An interactive Evaluation and Management (E/M) scoresheet tool is available at: www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet

     A review of submitted medical documentation finds that a high level of MDM was not met in the elements of 1) number and complexity of problems addressed 2) extensive level of amount and/or complexity of data to be reviewed 3) high risk of morbidity/mortality of patient management. DWC finds no documentation of time spent specifically on a separately identifiable E/M service in the submitted medical record.
   - Per CMS article, found at: Article - Billing and Coding: Nerve Conduction Studies and Electromyography (A57478) (cms.gov), "I. Coding Guidelines A.) Evaluation/Management (E/M) 1) Usually an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography. If the E/M service is a separate and identifiable service, the medical record must document medical necessity, and the CPT code must be billed with a modifier 25."
   - DWC applies Medicare's coding and billing policies in accordance with 28 TAC §134.203 as indicated above. Per Medicare Fee Schedule, CPT code 95909 has a global period of

XXX. According to National Correct Coding Initiative Policy Manual for Medicare Services, revised 5/1/2022, "… Many of these 'XXX' procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code… With most 'XXX' procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the 'XXX' procedure but cannot include any work inherent in the 'XXX' procedure, supervision of others performing the 'XXX' procedure, or time for interpreting the result of the 'XXX' procedure..."

Review of the submitted medical report dated April 28, 2025, finds that the disputed service of the evaluation and management, represented by CPT code 99205-25, was inherent to the performance of CPT code 95909 billed on the same date. The requester did not document a distinct and separately identifiable office visit to support the use of modifier "25".

For these reasons, DWC finds that the requester is not entitled to additional reimbursement for CPT code 99205-25 on the date of service in dispute.

3. The requester is seeking additional reimbursement in the amount of $8.65 for CPT code 95886, rendered on the disputed date of service. Per the submitted medical bill, on the date in dispute, the requester charged $198.64 for this service. Per the submitted explanation of benefits (EOB), the insurance carrier paid $188.99 for CPT code 95886.

   CPT code 95886 is described as "Needle Electromyography, each extremity, with related paraspinal areas, when performed 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."

   DWC finds that 28 TAC §134.203, described above, applies to the reimbursement of CPT code 95886. 28 TAC §134.203 states in pertinent part, "(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.

   The disputed date of service is April 28, 2025.

   - The disputed service was rendered in zip code 78228, locality 99, Rest of TX, carrier 4412.

- The Medicare participating amount for CPT code 95886 in 2025 at this locality is $87.11.
- The 2025 DWC Conversion Factor is 70.18.
- The 2025 Medicare Conversion Factor is 32.3465.
- Using the above formula, DWC finds the MAR is $189.00 for CPT code 95886 on the disputed date of service.
- The respondent paid $188.99.
- Additional reimbursement is not recommended.

DWC finds that the requester is not entitled to additional reimbursement for CPT code 95886 rendered on April 28, 2025.

4. The requester is seeking reimbursement in the amount of $5.65 for CPT code 95909 rendered on the disputed date of service. A review of the submitted medical bill finds that on the disputed date the requester charged $282.36 for the nerve conduction study service. Per the submitted EOB, the insurance carrier paid $269.03.

   CPT code 95909 is described as "Nerve conduction studies; five to six nerves."

   DWC finds that 28 TAC §134.203 as described above, applies to the reimbursement of CPT code 95909.

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

   The disputed date of service is April 28, 2025.
   - The disputed service was rendered in zip code 78228, locality 99, Rest of TX, carrier 4412.
   - The Medicare participating amount for CPT code 95909 in 2025 at this locality is $124.00.
   - The 2025 DWC Conversion Factor is 70.18.
   - The 2025 Medicare Conversion Factor is 32.3465.
   - Using the above formula, DWC finds the MAR is $269.03 for CPT code 95909 on the disputed date of service.
   - The respondent paid $269.03.
   - Additional reimbursement is not recommended.

   DWC finds that the requester is not entitled to additional reimbursement for CPT code 95909 on the disputed date of service.

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 for the services in dispute rendered on April 28, 2025.

ORDER

Under Texas Labor Code §§413.031, DWC has determined the requester is entitled to additional reimbursement in the amount of $0.00 for the disputed date of service April 28, 2025.

Authorized Signature

		October 8, 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.