



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

David West, D.O.

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-26-0608-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

November 3, 2025

Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| April 22, 2025 | 99205 | \$481.98 | \$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: \$481.98

Respondent's Position

"HCP submitted a request for reconsideration with no additional documentation to support reimbursement for 99205. All factors considered, HCP did not support reimbursement for 99205 thus payment denial was maintained. It should be noted that the POS was the home making this a telehealth visit. The Bill Review Vendor is under the belief that the higher two-level E/M codes require brick and mortar to fulfill the level of decision making described by AMA."

Response Submitted by: CorVel Healthcare Corporation

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

- 04P - Services unsubstantiated by documentation
- 95 - Services were provided via telemedicine
- 150 - Payment adjusted/unsupported service level
- W3 - Appeal/ Reconsideration
- Neither a HIGH level of Medical Decision Making (MDM) or Time spent has been adequately documented in the patient record (2021 CPT). Please recode & resubmit or provide additional documentation

Issues

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

Findings

1. The requester is seeking reimbursement in the amount of \$481.98 for CPT Code 99205-95 rendered on April 22, 2025. The insurance carrier denied the payment for the disputed date of service with denial codes listed above.

A review of the medical bill documents that the requester billed the insurance carrier CPT code 99205 with modifier 95 and place of service 10.

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."

- 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 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 E&M scoresheet tool is available at: <https://www.novitas-solutions.com/webcenter/portal/MedicareJL/EMScoreSheet>
- A review of the submitted medical documentation finds that a high level of MDM was not met in the elements of 1) Complexity/number of problems addressed 2) Amount or complexity of data reviewed and analyzed 3) Risk of morbidity or mortality of patient management. Submitted medical record shows no documentation of time spent on date of encounter. For these reasons, the medical documentation submitted did not meet AMA documentation criteria for CPT code 99205.

Because the medical documentation does not support the level of CPT code 99205, DWC finds that the insurance carrier's denial reason is supported

2. The DWC finds that since the insurance carrier's denial is supported, the requester is not entitled to reimbursement for the CPT code 99205 for date of service of April 22, 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.

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

Signature

Medical Fee Dispute Resolution Officer

December 17, 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, 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.