



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requester Name**

David West DO

**Respondent Name**

Old Republic

**MFDR Tracking Number**

M4-26-0779-1

**Insurance Carrier's Austin Representative**

BOX 44 White Espey PLLC

**DWC Date Received**

November 19, 2025

## Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2025	99205-95	\$481.98	\$481.90
<b>Total</b>		\$481.98	\$481.90

## Requester's Position

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

**Amount In Dispute:** \$481.98

## Respondent's Position

Our initial response to the above referenced medical fee dispute resolution is as follows: We have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

**Response Submitted By:** Gallagher Bassett

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

### Adjustment Reasons

Neither party submitted an explanation of benefits for the disputed services.

### Issues

1. What is DWC considering in this medical fee dispute?
2. What rule is applicable to reimbursement?
3. Is the requester due reimbursement?

### Findings

1. The requester is seeking reimbursement in the amount of \$481.98 rendered on March 18, 2025 and billed under code **99205**, 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, **-95** Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System.

Neither party submitted copies of EOBs with the request/response to medical fee dispute resolution. The insurance carrier did not support adjudication of this medical bill and only provided a supplemental response to MFDR indicating the medical bill had been escalated the bill for manual review.

The information available at the time of this review found the insurance did not support adjudication of the disputed service nor was a supplemental response made. The requester is therefore entitled to reimbursement for the service in dispute.

2. DWC Rule 28 TAC Section 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...

- (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 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 2025 DWC Conversion Factor 70.18.
  - The 2025 CMS Conversion Factor 32.3465.
  - CMS Physician Fee Schedule Allowable for zip code 77042 (Houston), Carrier Locality (0441218) is \$222.11
  - $70.18/32.3465 \times \$222.11 = \$481.90$
2. DWC finds that the requester submitted sufficient evidence demonstrating that the initial and reconsideration medical bills were sent to the insurance carrier for review and that no response was received. Accordingly, DWC determines that the requester is entitled to reimbursement in the amount of \$481.90.

### Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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.

### **Order**

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that Old Republic must remit to David West DO \$481.90 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

February 11, 2026

\_\_\_\_\_  
Date

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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](http://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 800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto: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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).