TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

David West DO

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-26-1802-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 17, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
September 9, 2025	99205-95	$481.98	$0.00
	Total	$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

The Austin carrier representative for Zurich American Insurance Co is Flahive, Ogen & Latson. The representative was notified of this medical fee dispute on February 25, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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

The insurance carrier denied payment for the disputed services with the following reasons:

- 5405 – This charge was reviewed through the clinical validation program.
- 6238 – After review of the bill and the medical record, this service is best described by 99203. Submitted documentation did not meet at least 2 of
- 90168 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the denial by the insurance carrier supported?

3. Has DWC determined if additional reimbursement is due to the requester?

Findings

1. The requester is seeking reimbursement of code 99205-95 in the amount of $481.98 for date of service September 9, 2025. The insurance carrier has denied the claim at the time of original adjudication and reconsideration based on level of service not supported. The rules applicable to the service is discussed below.

2. 28 TAC 133.210(c)(10) states, In addition to the documentation requirements of subsection

(b) of this section, medical bills for the following services shall include the following supporting documentation:
(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

Review of the information available at the time of this review found, the Consultation Report dated September 9, 2025 via Telemedicine. As seen above the submitted medical documentation must satisfy the American Medical Association requirement for submitted code.

The AMA requirement for 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.

The requirements required per the AMA for a high level of decision making is listed below.

- Number and Complexity of Problems addressed at the Encounter
    - One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.
- Amount and/or Complexity of Data to be Reviewed and Analyzed.
    - Extensive – must meet the requirements of at least 2 out of 3 categories
    - Tests, documents or independent historians or
    - Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) or Discussion of management or
    - Test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported).
- Risk of Complications and/or Morbidity or Mortality of Patient Management
    - High risk of morbidity from additional diagnostic testing or treatment.

The information found in the Consultation Report does not support a High level of decision making.

3. DWC has reviewed the information available at the time of this review and found insufficient information to support the level of service submitted on the medical bill nor did the requester submit additional information in support of submitting code 99205-95. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 not established that reimbursement is due.

Order

Under Texas Labor Code Sections 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	May 22, 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. 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.

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 electronico CompConnection@tdi.texas.gov.