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

Cesar Duclair MD

Respondent Name

ZNAT Insurance Co

MFDR Tracking Number

M4-26-2166-01

Insurance Carrier's Austin Representative

BOX 47 Burns Anderson Jury Brenner & Donovan

DWC Date Received

April 3, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 20, 2025	99205-25	$481.98	$0.00
December 20, 2025	95886	$0.00	$0.00
December 20, 2025	95912	$0.00	$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

"CPT code 99205-25 was billed in combination with nerve conduction studies (95912) and an electromyography test (95886). Dr Duclair's medical report shows that the history, the examination, and the medical decision-making are related to the related to the reason for the nerve conduction studies. Therefore, no additional payment is due for the disputed code 99205-25 as the provider's

report does not support a significant and separately identifiable E&M service unrelated to the decision to perform the nerve conduction studies."

Response Submitted By: TheZenith

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 133.210 sets out the requirements for medical bill processing by insurance carrier.
3. 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:

- 205 – TX This charge was disallowed as additional information/definition is required to clarify service/supply rendered.
- 225 – TX The submitted documentation does not support the service being billed. We will re-evaluated this upon receipt of clarifying information.
- 446 – TX This add-on code has been denied as the principal procedure was not billed.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule(s) applies to coding and payment of disputed service?
3. Has DWC determined whether reimbursement is due for code 99205-25?

Findings

1. The requester is seeking $481.98 for code 99205-25 rendered on December 20, 2025. Codes 95886 and 95912 listed on the DWC060 have zero amount in dispute.

2. 28 TAC Section 133.210(c)(1) 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;

The submitted code 99205 has a AMA definition of, 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.

28 TAC Section 134.203(5) defines "Medicare payment policies" …shall mean reimbursement methodologies, models, and values or weights including its coding, billing and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

The respondent states, "…the provider's report does not support a significant and separately identifiable E/M service unrelated to the decision to perform the nerve conduction studies.

The Medicare payment policy applicable to services at www.cms.gov, is Chapter Xi Medicine and Evaluation and Management Services Cpt Codes 90000 - 99999 For Medicare National Correct Coding Initiative Policy Manual, U. Evaluation & Management (E&M) Services

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intraprocedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them.

A provider/supplier shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure 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 bill found use of the 25 modifier defined as, 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond

the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service).

The medical bill submission of code 99205-25 requires the submitted documentation to meet the criteria of high level decision making and substantiate a separate identifiable evaluation.

Code 99205 requires a high level of decision. The requirements required per the American Medical Association Guidelines (AMA) 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.

Review of the "EMG/NCV – Consultation and Testing Report" does not support the requirements of a high level of decision making described above. The requester did not submit any evidence to support the requirements of the submitted code 99205.

The use of modifier 25 appended to code 99205 was not supported by the "EMG/NCV – Consultation and Testing Report" as a separately identifiable evaluation.

Additionally, the CMS Billing and Coding" Nerve Conduction Studies and Electromyography A54969 at https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=54969, I. Coding Guidelines. A. Evaluation/Management(E/M) states,

1. **Usually an E&M service is included in the exam performed just prior to and during nerve conduction studies and/or electromyography.**

Based on the above, the AMA requirements of 99205 is not met nor does the submitted documentation support a separately identifiable service required for the use of the 25 modifier.

3. The review of the information available at the time of this review found the submitted documentation does not support the high level of decision making required for code 99205 and the appended 25 modifier is not supported as a separately identifiable procedure. 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

		May 1, 2026
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 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.