TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NINALA, RANIL

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-21-0597-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
November 30, 2020

REQUESTOR'S POSITION SUMMARY

"POST DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED … **THIS EVALUATION WAS AT THE REQUEST OF THE PATIENT'S ATTORNEY TO DISPUTE AN RME BY THE CARRIER BEFORE A CCH. THE LETTER REGARDING THE CCH IS ATTACHED."

Amount in Dispute: $1,700.00

RESPONDENT'S POSITION SUMMARY

"The Office found that Dr. Valdez performed an MMI/IR exam of the injured worker on 9/4/2019 where he placed [the injured employee] at MMI and gave … a 9% impairment rating. A Designated Doctor exam was then performed by Dr. Lawrence on 9/5/2019 where he placed the injured employee at MMI with 14% impairment rating. A Post DD RME was requested for an alternate rating and performed by Dr. Brylowski on 3/11/20 where he placed [the injured employee] at MMI with a 5% Impairment rating.

While Dr. Ninala might argue that a second alternate rating was requested, Texas Labor Code 408.0041(h) is clear that the carrier shall pay for one (1) exam."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2020	Examination to Determine Maximum Medical Improvement, Impairment Rating, and Extent of Injury (99456-WP, 99456-RE, 99456-MI)	$1,700.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, us only if no other code is applicable.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Note: "PER TEXAS LABOR CODE 408.0041(F-2)(H) AS THE INJURED EMPLOYEE HAS ALREADY BEEN ASSESSED WITH MMI/IR ON OR BY THE TREATING DR. AND A DESIGNATED DR."

Issues

Is Ranil Ninala, M.D. entitled to reimbursement for the examination in question?

Findings

Dr. Ninala is seeking reimbursement for an examination to determine maximum medical improvement, impairment rating, and the extent of the compensable injury.

The insurance carrier argued that , "The plain language of the statute indicates that the Carrier is only liable for one examination to determine MMI and IR under each of the Subsections including (f) which refers to the treating doctor examination or examination by a doctor selected by the treating doctor." The DWC agrees.[1] Because the injured employee was seen by a designated doctor and a doctor in place of the treating doctor prior to the examination in question, no reimbursement can be recommended for this examination.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 10, 2021 Date

[1] TLC §408.0041 (f-2)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.