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

Requestor Name
Ranil Ninala, M.D.

Respondent Name
New Hampshire Insurance Co.

MFDR Tracking Number
M4-21-1995-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
July 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 7, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$300.00

Requestor's Position

"CERTIFYING DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $650.00

Respondent's Position

"Upon receipt of the MDR requested, the bill was sent for reconsideration. Payment of $350.00 was issued on 7-29-21."

Response Submitted by: ESIS

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 216 – Based on the findings of a review organization.
- TX06 – Unnecessary treatment with peer review
- 148 – This procedure on this date was previously reviewed
- 18 – Duplicate claim/service
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Notes: "Additional recommendations is based upon additional supporting documentation received."

Issues

1. Did New Hampshire Insurance Co. maintain its denial based on medical necessity?

2. Is Ranil Ninala, M.D. entitled to additional reimbursement?

Findings

1. Dr. Ninala is seeking additional reimbursement for an examination to determine maximum medical improvement. Per explanations of benefits dated November 14, 2020, and December 14, 2020, the insurance carrier denied payment based on medical necessity.

   The insurance carrier paid the disputed charges in part after the request for medical fee dispute resolution. DWC concludes that the insurance carrier did not maintain its denial based on medical necessity.

2. The submitted documentation supports that Dr. Ninala performed an evaluation of maximum medical improvement. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is $350.00.

   Review of the submitted documentation finds that Dr. Ninala performed impairment rating evaluations of the left middle finger with range of motion testing. The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00. The total MAR for the determination of impairment rating is $300.00.

   The total allowable amount for the examination in question is $650.00. The insurance carrier paid $350.00. An additional reimbursement of $300.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $300.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co. must remit to Ranil Ninala, M.D. $300.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 15, 2021 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, please 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 electronico CompConnection@tdi.texas.gov.