

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Ranil Ninala, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-22-0500-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

November 9, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 11, 2021	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	\$0.00	\$0.00
January 11, 2021	Examination to Determine the Ability to Return to Work (99456-RE)	\$500.00	\$0.00
January 11, 2021	Examination to Determine Disability Related to the Compensable Injury (99456-RE)	\$250.00	\$0.00
Total		\$750.00	\$0.00

Requestor's Position

PLEASE NOTE THAT POST DD DOCTOR ADDRESSED BOTH DISABILITY AND RETURN TO WORK QUESTIONS BECAUSE THE PATIENT AND TREATING DOCTOR DID NOT AGREE WITH THE OPINION OF THE DD DOCTOR PATIENT HAD SEEN PRIOR.

Amount in Dispute: \$750.00

Respondent's Position

Documentation submitted with the DWC60 includes the DWC69 which confirms that Ranil Ninala MD is the doctor selected by treating.

Further review of the claim file and documentation on file does not confirm that DWC or Texas Mutual Insurance Company requested an RME or Post DD alternate rating exam until February 2022.

Our position is no payment is due.

Response Submitted by: Texas Mutual Insurance Company

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 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.235 sets out the fee guidelines for examinations to determine return to work and disability.

Denial Reasons

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

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891 – No additional payment after reconsideration
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions.
- Notes: "892/225 – DOCUMENTATION STATES THIS IS A POST DD RME. DWC 69 INDICATES THIS IS A DR SELECTED."

Issues

1. Is Texas Mutual Insurance Company's denial supported?

Findings

1. Ranil Ninala, M.D. is seeking reimbursement of examinations performed on January 11, 2021. Dr. Ninala is seeking \$0.00 for the examination to determine maximum medical improvement and impairment rating. Therefore, this examination will not be considered in this dispute.

Dr. Ninala is seeking \$750.00 for examinations to determine the ability of the injured employee to return to work and whether disability is related to the compensable injury. The insurance carrier denied the charges, in part, stating, "DOCUMENTATION STATES THIS IS A POST DD RME. DWC 69 INDICATES THIS IS A DR SELECTED."

Per 28 TAC §134.235, An examination to determine return to work or disability is billed using CPT code 99456 with modifier "RE" only when the examination was requested by the DWC or the insurance carrier. No evidence was received to support that the examination in question was requested by the DWC or the insurance carrier.

DWC finds that Texas Mutual Insurance Company's denial of the disputed services is supported. No reimbursement 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

_____	_____	February 18, 2022
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 §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 electrónico CompConnection@tdi.texas.gov.