TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Ranil Ninala, M.D.

Respondent Name
Indemnity Insurance Co. of North America

MFDR Tracking Number
M4-24-0393-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
October 18, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 20, 2023	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456-WP	$0.00	$0.00
	Examination to Determine Extent of Compensable Injury – 99456-RE	$0.00	$0.00
	Examination to Determine Ability to Return to Work – 99456-RE	$250.00	$0.00
	Examination to Determine Whether Disability is Related to the Injury – 99456-RE	$125.00	$0.00
	Multiple Impairment Ratings – 99456-MI	$50.00	$0.00
	Work Status Form – 99080-73	$15.00	$0.00
	Total	$440.00	$0.00

Requestor's Position

"POST DESIGNATED DOCTOR EXAM INCORRECT REDUCTION"

Amount in Dispute: $440.00

Respondent's Position

"This payment has been denied as the bill does not have the required modifiers W6-W9. We

have emailed and called the provider to request the corrected billing, but to date we have not received a response. Once the corrected billing is received, we will proceed with processing it."

Response Submitted by: Broadspire

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §126.17 sets out the guidelines for treating or referral doctors after a designated doctor to address issues other than maximum medical improvement and impairment rating.
2. 28 TAC §129.5 sets out the guidelines for work status forms.
3. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 TAC §134.235 sets out the fee guidelines for certain examinations to determine extent of injury, return to work, and disability.
5. 28 TAC §134.239 sets out the fee guidelines for work status reports .
6. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

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

- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- 308 – MMI/IR procedure code 99456 is permitted only once on the same date of service.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
- 96 – Non-covered charge(s).
- B15 – This service/procedure requires that a qualifying service/procedure be received and covered the qualifying other service/procedure has not been received/ adjudicated.
- 219 – this procedure, supply, service or report does not normally warrant a charge.

- N429 – Not covered when considered routine.

Issues

1. What services are considered in this dispute?

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

Findings

1. Dr. Ninala is seeking reimbursement for an examination after a designated doctor in response to the findings of the designated doctor. Dr. Ninala is seeking $0.00 for the examinations to determine maximum medical improvement, impairment rating, and extent of the compensable injury. Therefore these services will not be considered in this dispute.

   Dr. Ninala is seeking reimbursement of $440.00 for examinations to determine the ability of the injured employee to return to work, whether disability was related to the compensable injury, providing multiple impairment ratings, and a work status form. These are the services considered in this dispute.

2. Dr. Ninala billed the examinations to determine the ability to return to work and disability with procedure code 99456 and modifier "RE." Per 28 TAC §134.235, an examination to determine return to work or disability represented by CPT code 99456 and modifier "RE" is limited to examinations requested by the DWC or the insurance carrier. No evidence was received to support that the examinations in question were requested by the DWC or the insurance carrier. Therefore, Dr. Ninala is not entitled to reimbursement for the disputed services billed with these codes.

   Dr. Ninala is seeking reimbursement for the calculation of an additional impairment rating given as part of an examination performed at the request of injured employee as referred by the treating doctor. 28 TAC §134.250(4)(B) reserves reimbursement for multiple impairment ratings performed as part of a **designated doctor** examination. Because this service was not provided as part of a designated doctor examination, no reimbursement can be recommended.

   Per 28 TAC §134.239, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title." DWC finds that Dr. Khalifa, a doctor selected by the treating doctor acting in place of the treating doctor, provided a work status report that was not conducted as part of the examinations outlined in 28 TAC §§134.240 and 134.250. Therefore, billing for this report is subject to the rules found in 28 TAC §129.5 which states,

   > (e) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:
   >
   > (1) after the initial examination of the injured employee, regardless of the injured employee's work status;

(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and

(3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee …

(g) In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:

(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or

(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions …

(j) Notwithstanding any other provision of this title, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy …"

The DWC finds that the submitted evidence does not meet the requirements to support billing for completion of the DWC073 as outlined in 28 TAC §129.5. No reimbursement is recommended for this service.

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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 1, 2024 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 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 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 tres o correo electronico CompConnection@tdi.texas.gov.