



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Ranil Ninala, M.D.

**Respondent Name**

Employers Preferred Insurance

**MFDR Tracking Number**

M4-25-2326-01

**Carrier's Austin Representative**

Box Number 04

**DWC Date Received**

May 21, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 12, 2024	Designated Doctor Examination 99456-W5	\$109.00	\$0.00
		\$142.00	\$0.00
<b>Total</b>		<b>\$251.00</b>	<b>\$0.00</b>

### Requester's Position

"99456 RATE FOR POST DESIGNATED DOCTOR EXAM WITH NO MUSCULOSKELETAL BODY AREA WHOLE PERSON IMPAIRMENT RATING IS \$641.00 BILL INCORRECTLY REDUCED TO \$390.00."

**Amount in Dispute:** \$251.00

### Respondent's Position

"Please see attached proof of payments."

**Response Submitted by:** Ricky D. Green

## 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 \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.

### Denial Reasons

Explanations of benefits for the services in question included the following claim adjustment codes:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 2005/5280 – No additional reimbursement allowed after review of appeal/reconsideration
- 2008 – Additional payment mad on appeal/reconsideration.

### Issues

1. Is Ranil Ninala, M.D. entitled to additional reimbursement for the services in question?

### Findings

1. Dr. Ninala is seeking additional reimbursement for services billed with procedure code 99456 and identified as "POST DESIGNATED DOCTOR EXAM WITH NO MUSCULOSKELETAL BODY AREA WHOLE PERSON IMPAIRMENT RATING" in the position statement.

According to the bill submitted with this dispute, Dr. Ninala billed a total of \$641.00 for the services in question.

Per explanations of benefits submitted to DWC, dated September 18, 2024; December 4, 2024; and April 28, 2025, the insurance carrier paid a total of \$790.00.

DWC finds that Dr. Ninala is not entitled to additional reimbursement for the services in question.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester 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 requester is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	August 28, 2025
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).