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

Requester Name
Ranil Ninla, MD

Respondent Name
XL Insurance America Inc

MFDR Tracking Number
M4-25-3208-01

Insurance Carrier's Austin Representative
BOX 19 Flahive Ogden & Latson

DWC Date Received
August 6, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 14, 2025	99456	$449.00 ($0.00)	$0.00
March 14, 2025	99546 x 3	$769.00 ($192.00)	$192.00
	Total	$1,218.00	$192.00

Requester's Position

"The carrier has incorrectly denied this claim in its entirety... REPORT WAS ATTACHED ON THE BILL AND ALSO THE RECONSIDERATION AND DATE OF SERVICE WAS CORRECTED. NO RESPONSE OR EOB FROM THE RECONSIDERATION."

Amount In Dispute: $1,218.000

Respondent's Position

"The bill related to the above captioned MDR has been reprocessed and payment was made 08/15/2025 with interest being paid on 09/19/2025. A copy of the EOR and payment ledger for the bill payment issued is attached. Please let me know if you have any questions."

Response Submitted By: ESIS

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.305 MDR -- General.
2. 28 TAC Section 134.260 Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referred Doctors.
3. 28 TAC Section 133.307 Medical Fee Dispute Resolution.
4. 28 TAC Section 141.1 Requesting and Setting a Benefit Review Conference.
5. Labor Code Section 413.031 Medical Dispute Resolution.

Adjustment Reasons

1. 222 – Charge exceeds fee schedule allowance.
2. P12 – Workers compensation jurisdictional fee schedule adjustment.
3. CIQ377 – Additional recommendation is based upon additional supporting documentation received.
4. Note 1 – Previous gross recommended payment amount on line $0; Previous recommended payment amount on line: $0, Additional recommended allowance of $449.00 is being made based upon additional supporting documentation received.
5. Note 2 – Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line: $0, Additional recommended allowance of $577.00 is being made based upon additional supporting documentation received.
6. RARCM5-M51 – Missing/incomplete/invalid procedure code(s).
7. W3 – A payment or denial has already been recommended for this service.
8. RE555 – Previous recommended history on DCN(s)…

Issues

1. What is DWC considering in this dispute?
2. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester seeks reimbursement in the amount of $1,218.00 for a certifying doctor examination referred to by the treating doctor, to determine maximum medical improvement (MMI) and impairment rating rendered on March 14, 2025.

   A review of the submitted documentation finds that the insurance carrier issued a payment in the amount of $449.00 and $577.00, for a total payment of $1,026.00. The requester seeks an additional payment of $192.00. The disputed service is therefore reviewed pursuant to the applicable rules and guidelines to determine if the requester is entitled to an additional payment of $192.00.

2. The requester seeks an additional payment of $192.00 for a certifying doctor examination referred by the treating doctor, pursuant to 28 TAC §134.260(c)(3)(A)(ii)(II). A review of the submitted documentation shows that the requester billed three impairment ratings (IRs) but was reimbursed for only two. The requester is entitled to an additional payment of $192.00.

Conclusion

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

DWC finds the requester has established that reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that respondent, must remit to the requester $192.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		January 23, 2026
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 Section 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 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.