



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Ranil Ninala, M.D.

Respondent Name

Ace American Insurance Co.

MFDR Tracking Number

M4-26-0295-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

September 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 30, 2025	Examination to Determine MMI 99456	\$449.00	\$0.00
May 30, 2025	Examination to Determine IR 99456	\$1,153.00	\$0.00
Total		\$1,602.00	\$0.00

Requester's Position

"CARRIER DENIED THE BILL FOR INCORRECT IDC-10 CODES. THE CODES WERE CORRECTED AND WE HAVE RECEIVED NO RESPONSE ON THE RECONSIDERATION"

Amount in Dispute: \$1,602.00

Respondent's Position

"Submitted documentation has a referring provider listed in CMS-1500/field 17. No state license number was found in CMS-1500/field 17a."

Response Submitted by: ESIS

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) [§133.10](#) sets out the procedures for completing a medical bill.
2. 28 TAC [§133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- SR101 – Bill is denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review.
- SR107 – Bill is denied; invalid/missing referring provider license number. Please re-submit with appropriate license number for review.
- 418 – Resubmit bill with appropriate ICD-10 diagnosis codes: ... are invalid
- 146 – Diagnosis was invalid for the date(s) of service reported.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- SR101 – Bill is denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review.
- SR107 – Bill is denied; invalid/missing referring provider license number. Please re-submit with appropriate license number for review.

Issues

1. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating as referred by the injured employee's treating doctor. The insurance carrier denied reimbursement, in part, based on invalid or missing referring provider license number.

28 TAC §133.10(f)(1)(K) requires the "referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider must enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX')."

The medical bills submitted with this dispute include a referring provider in CMS-1500/field 17, but does not include the referring provider's license number. No evidence was submitted indicating that a medical bill with the required information was submitted to the insurance carrier.

DWC finds that the requester is not entitled to reimbursement for the services in dispute.

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 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

Signature

Medical Fee Dispute Resolution Officer

January 8, 2026

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 electrónico CompConnection@tdi.texas.gov.