



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Ninala Ranil MD

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-26-0783-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

November 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 24, 2025	99205-25	\$26.38	\$0.00
March 24, 2025	95886	\$19.25	\$0.00
March 24, 2025	95911	\$20.95	\$0.00
Total		\$66.61	\$0.00

Requestor's Position

"The insurance carrier has not properly paid this claim in accordance with DWC Rules governing the specific services billed."

Amount in dispute: \$66.61

Respondent's Position

"The EOB attached shows that the bill was reduced by \$66.61 based on the 2025 CMS rates. The provider used the 2024 rates and therefore came up with a different reimbursement rate. No additional is due."

Response Submitted by: Broadspire

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 §134.203](#) sets out the fee guidelines for professional medical services.

Denial Reasons

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

- D00 – Based on further review, no additional allowance is warranted.
- G15 – Pricing is calculated based on the medical professional fee schedule value.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What rules are applicable to reimbursement?
2. Is requester entitled to additional reimbursement?

Findings

1. The requester is seeking additional payment for professional medical services rendered in March of 2025. The insurance carrier reduced the billed amount based on the workers' compensation fee schedule. DWC Rule 28 TAC §134.203 states in pertinent part, (c) To determine the Maximum Allowable Reimbursement (MAR) for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 - (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
 - (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

The following formula represents the calculation of the DWC MAR at §134.203 (c)(1) & (2).

(DWC Conversion Factor ÷ Medicare Conversion Factor) x Medicare Payment = MAR. In this instance,

- The 2025 DWC Conversion Factor 70.18
- The 2025 CMS Conversion Factor 32.3465
- CMS Physician Fee Schedule Allowable for zip code 78228 (Rest of Texas) San Antonio is as follows.
- 99205 – $70.18/32.3465 \times \$209.99 = \455.60 . Carrier paid \$455.60. No additional payment due.
- 95886 – $70.18/32.3465 \times \$87.11 = \$189.00 \times 2 = \$377.99$. Carrier paid \$378.00. No additional payment due.
- 95911 – $70.18/32.3465 \times \$194.84 = \422.73 . Carrier paid \$422.73. No additional payment due.

2. Review of the information available at the time of this review found the insurance carrier paid the Maximum Allowable Reimbursement (MAR) no additional payment is due.

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 entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

December 29, 2025
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.