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 Ninala, M.D.

**Respondent Name**

Accident Fund Natl Ins

**MFDR Tracking Number**

M4-26-1361-01

**Insurance Carrier's Austin Representative**

BOX 6 Stone Loughlin & Swanson LLP

**DWC Date Received**

January 15, 2026

## Summary of Findings

| Date(s) of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| April 15, 2025 | Examination to Determine Eligibility for LIBs 99456 | $1,250.00 | $0.00 |
| | **Total** | $1,250.00 | $0.00 |

## Requester's Position

"NO RESPONSE TO ORIGINAL BILL AND RECONSIDERATION"

**Amount In Dispute:** $$1,250.00

## Respondent's Position

"The bill for this service was initially received on 07/14/25 and denied requesting required form DWC069 on 08/20/25. A request for reconsideration was received on 11/18/25 and was denied requesting the required form DWC069 on 12/29/25. To date, no form DWC069 has been received, and none is attached to this MDFR. Once the required form is received from the provider these charges will be reviewed for reimbursement according to the fee schedule."

**Response Submitted By:** Stone Loughlin Swanson

# 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 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 126.17 sets out the procedures for a treating doctor or referral doctor to address issues other than maximum medical improvement and impairment rating.
3. 28 TAC Section 134.260 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a referred doctor.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

1. @G(W3) – No additional reimbursement allowed after review of appeal/reconsideration.
2. 5178 – RECON: We have received no documentation that would alter our original recommendation. For this reason, it is our position that no additional reimbursement is due.
3. 965 – State required form was not submitted
4. TX W3 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the insurance carrier's denial based on missing documentation supported?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for an examination to determine if the injured employee qualified for lifetime income benefits performed on April 15, 2025. The insurance carrier denied payment for lack of "required form DWC069." This is the service considered in this dispute.

2. Form DWC069 is titled "Report of Medical Evaluation." This form is used to certify maximum medical improvement and impairment rating. No evidence was provided indicating that such an examination was performed. Therefore, this form would be inappropriate for the examination in question. The insurance carrier's denial for this reason is not supported.

3. Dr. Ninala billed the service in question with CPT code 99456. 28 TAC Section 126.17(a) provides that a doctor referred by the treating doctor may address any issue other than MMI and IR if:

   - A designated doctor has issued an opinion on the issue;
   - The injured employee is not satisfied with the designated doctor's opinion; and
   - The referral doctor has not already provided an opinion on the issue.

   No evidence was provided to support the conditions noted above.

   DWC also finds that neither 28 TAC Section 126.17 nor 28 TAC Section 134.260 assign procedure code 99456 to this service. No reimbursement can be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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 not established that reimbursement is due.

## Order

Under Texas Labor Code Sections 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 | May 13, 2026<br>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.