



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Tyler Johnson, D.C.

Respondent Name

Travelers Casualty & Surety Co

MFDR Tracking Number

M4-25-2230-01

Carrier's Austin Representative

Box Number 05

DWC Date Received

May 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 6, 2024	Designated Doctor Examination 99456-W5	\$834.00	\$0.00

Requester's Position

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$834.00

Respondent's Position

"This dispute is being paid in full now, see EOR attached. We had never received the original submission so the 1st bill we received was the dispute which was then denied for timely filing."

Response Submitted by: StrataCare

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

The insurance carrier paid the disputed services with the following claim adjustment codes:

- 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.
- 2008 – Additional payment made on appeal/reconsideration.

Issues

1. Is Tyler Johnson, D.C. entitled to additional reimbursement?

Findings

1. Dr. Johnson is seeking reimbursement of \$834.00 for a designated doctor examination performed on September 6, 2024. Per explanation of benefits dated July 10, 2025, the insurance carrier paid this amount in full. No further reimbursement is recommended.

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

Signature

Medical Fee Dispute Resolution Officer

August 28, 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 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.