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
Terry D. Williams, D.C.

Respondent Name
Texas Mutual Insurance Co.

MFDR Tracking Number
M4-25-3426-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 17, 2024	99456	$1,026.00	$0.00

Requester's Position

"This claim was denied for a clerical error on the date of service. All other claims for this patient have been approved and paid in full. Our position is that this claim is also a legitimate claim for approval of payment."

Amount in Dispute: $1,026.00

Respondent's Position

"To resolve this fee reimbursement dispute, Texas Mutual has elected to reprocess the disputed services in accordance with the appropriate Medical Fee Guideline as defined per Texas Administrative Code Rule 134 - Guidelines for Medical Services, Charges and Payments."

Response submitted by: Texas Mutual Insurance Co.

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 Medical Fee Dispute Resolution requests.

Adjustment Reasons

Per the explanation of benefits (EOB) dated September 12, 2025, the insurance carrier allowed reimbursement for the disputed services with the following claim adjustment codes:

- 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.
- 45 - CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- DC3 - ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- 920 - REIMBURSEMENT IS BEING ALLOWED BASED UPON A DISPUTE.

Issues

1. Have the services in dispute been allowed reimbursement as of the date of this review?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking reimbursement in the total amount of $1,026.00 for disputed services rendered on October 17, 2024.

A review of the submitted documentation finds that the requester billed the insurance carrier a total amount of $1,026.00 for designated doctor examination services rendered on October 17, 2024.

A review of the submitted explanation of benefits (EOB) dated September 12, 2025, finds that the disputed designated doctor services have been allowed reimbursement in the total amount of $1,026.00 plus interest.

A review of the EOBs submitted finds that the designated doctor examination services in dispute, rendered on October 17, 2024, have been allowed reimbursement in the total amount of $1,026.00 plus interest as of the date of this review.

2. DWC finds, according to the EOBs submitted, that as of the date of this review, the requester has been allowed reimbursement for charges in full for the disputed date of service October 17, 2024. Therefore, no additional 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 additional reimbursement for the disputed services.

Authorized Signature:

		October 20, 2025
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 §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 electronico CompConnection@tdi.tas.gov.