



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Joe Huggins, D.C.

**Respondent Name**

East TX Educational Insurance Assn

**MFDR Tracking Number**

M4-26-0356-01

**Insurance Carrier's Austin Representative**

BOX 17 Downs Stanford PC

**DWC Date Received**

October 3, 2025

### Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 5, 2025	Examination to Determine MMI 99456	\$465.00	\$0.00
May 5, 2025	Examination to Determine IR 99456	\$398.00	\$0.00
<b>Total</b>		<b>\$863.00</b>	<b>\$0.00</b>

### Requester's Position

The submitted documentation does not include a position statement from the requester. Accordingly, this decision is based on the information available at the time of adjudication.

**Amount In Dispute:** \$863.00

### Respondent's Position

"Carrier asserts that it timely and properly paid the bill for date of service May 5, 2025. Carrier received the initial bill on May 18, 2025. The requestor billed \$863.00 for the May 5, 2025 MMI/IR examination. Carrier timely paid \$863.00 without any bill reductions on June 27, 2025."

**Response Submitted By:** Claims Administrative Services, Inc.

## 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.

### Adjustment Reasons

Submitted explanations of benefits indicate payment in full.

### Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to the reimbursement in dispute?

### Findings

1. The requester is seeking reimbursement of \$863.00 for an examination to determine maximum medical improvement and impairment rating as referred by the treating doctor.

The documentation submitted to DWC with this dispute includes an explanation of benefits dated June 27, 2025. This document indicates that the insurance carrier reimbursed the requester in full.

2. Because the evidence supports reimbursement in full by the insurance carrier, no additional reimbursement can be recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence 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

February 4, 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 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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).