



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Emergency Addison Physicians PLLC

Respondent Name

Texas Mutual Insurance Co.

MFDR Tracking Number

M4-26-0392-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 7, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 17, 2025	99284	\$6,759.20	\$0.00
March 17, 2025	12002	\$3,206.42	\$0.00
March 17, 2025	73080	\$1,410.70	\$0.00
Total		\$11,376.32	\$0.00

Requester's Position

"All documentation was sent to the insurance carrier with changes made to the HCFA-1500 form. All EOB's including the original denial was included as well. Texas Mutual has either not verified all information was included or has decided not to review, therefore denying our request for payment again."

Amount in Dispute: \$11,376.32

Respondent's Position

"On 03/26/2025, Texas Mutual received the attached billing. Documentation submitted with the bill states that Andrew Hay, RN was the provider, however, the billing provider listed on the HCFA is Vinh Mai.

"On 05/01/2025, Texas Mutual received the attached appeal. Documentation submitted with the bill states Shahroz Kidwai, MD was the provider, however, the billing provider listed on the HCFA is Vinh Mai."

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 \(TAC\) §133.307](#) sets out the procedures for Medical Fee Dispute Resolution requests.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission by health care providers.
3. [28 TAC §133.10](#) sets out health care provider billing procedures.
4. [28 TAC §134.600](#) sets out procedures for prospective and concurrent review of health care.

Denial Reasons

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

- Comments - DC4, A19 - PROVIDER NEEDS TO UPDATE INFORMATION TO MATCH BOX 24J AND BOX 31 OF THE HCFA TO REFLECT THE RENDERING PROVIDER'S INFORMATION. PLEASE CORRECT AND SUBMIT A REQUEST FOR RECONSIDERATION.
- A19 - DWC RULES 133.10, 133.20 & CLEAN CLAIM GUIDE REQUIRE LICENSE TYPE, TAX 10, NPI & STATE JURISDICTION OF LICENSED HCP WHO RENDERED SERVICES.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

- W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
- 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.

Issues

1. Did the requester correctly submit a complete medical bill for the services in dispute in accordance with 28 TAC §133.10(f)?
2. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for emergency medical services rendered on March 17, 2025.

28 TAC §133.10(f) sets out required medical billing formats and states in pertinent part, "(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

"(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: ...

"(U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider must enter the 'OB' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;"

A comparison of the submitted medical bill and the submitted medical documentation finds that the rendering provider named in the medical record does not match the rendering provider information on the medical bill in field 24J and in field 31.

Due to the discrepancy of the rendering provider on the medical bill compared to the rendering provider on the medical record, DWC finds that the requester did not submit a correct and complete medical bill for the services in dispute as required by 28 TAC §133.10(f).

2. The requester is seeking reimbursement in the amount of \$11,376.32 for emergency medical services rendered on March 17, 2025.

Because the medical bill and medical record review found that the requester did not submit a correct complete medical bill in accordance with 28 TAC §133.10(f), DWC finds that the requester is not entitled to reimbursement.

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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to reimbursement in the amount of \$0.00 for the disputed date of service March 17, 2025.

Authorized Signature:

October 22, 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 electrónico CompConnection@tdi.tas.gov.