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

Rochelle Mayfield, D.C.

Respondent Name

Benchmark Insurance Co

MFDR Tracking Number

M4-26-0818-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

November 20, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
June 20, 2025	Designated Doctor Examination 99456-W5	$449.00	$0.00
June 20, 2025	Designated Doctor Examination 99456-W5	$385.00	$0.00
	Total	$834.00	$0.00

Requester's Position

"NO RESPONSE OR CORRESPONDENCE TO ORIGINAL BILL OR RECONSIDERATION"

Amount In Dispute: $834.00

Respondent's Position

"On July 9, 2025, the Carrier processed the Provider's medical bill and recommended payment of $834. A check was issued to the provider in the amount of $834 on July 10, 2025. However, it does not appear that the payment has cleared … Since the Carrier is in agreement that the Provider is entitled to reimbursement of $834, the Provider should withdraw her request for Medical Fee Dispute Resolution."

Response Submitted By: Flahive, Ogden & Latson

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

The services in question were reviewed with the following adjustment codes:

1. 4150 An allowance has been paid for a designated doctor examination as outlined in 134.204(j) For attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed.

2. P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requester is seeking $834.00 reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier argued that full payment was paid.

2. The insurance carrier provided evidence to support that payment was made in the full amount requested for the services in question. No additional reimbursement is 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 additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 9, 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. 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.