



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

William Defoyd, D.C.

Respondent Name

City of Austin

MFDR Tracking Number

M4-26-1721-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

February 18, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 11, 2025	Examination to Determine MMI and IR 99456	\$834.00	\$834.00
Total		\$834.00	\$834.00

Requester's Position

"The requestor did not receive an Explanation of Benefits (EOB) for the disputed dates of service ... The original medical bill was submitted to the insurance carrier on October 2, 2025, ... Additionally, a facsimile transmission was sent to the carrier on Thursday, December 4, 2025, ..."

Amount In Dispute: \$834.00

Respondent's Position

The Austin carrier representative for City of Austin is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 20, 2026.

Per 28 Texas Administrative Code Section 133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

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.
2. 28 TAC Section [134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a referred doctor.

Adjustment Reasons

Neither party submitted an explanation of benefits for the disputed services.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the insurance carrier submit explanations of benefits (EOBs) for the disputed services?
3. Is the requester entitled to reimbursement?

Findings

1. The requester is seeking reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) as referred by the treating doctor. No response to this dispute was received from the insurance carrier. DWC will review these services in accordance with appropriate rules.
2. The requester argued that it did not receive payment or an explanation of denial for medical bills submitted for the examination in question.

Per 28 TAC Section 133.240(a), the insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.

The greater weight of evidence presented to DWC indicates that a complete bill for the services in question was received by the insurance carrier or its agent. DWC found no evidence that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier provided no defense for its non-payment of the services in question, DWC finds that the requester is entitled to reimbursement calculated below.

28 TAC Section 134.260(c)(2) states, in relevant part, "MMI evaluations will be reimbursed at \$449 adjusted per Section 134.210(b)(4)." The adjusted reimbursement amount for the date of service in question is \$465.00.

28 TAC Section 134.260(c) states, in relevant part,

(3) For IR examinations, the referred doctor must bill, and the insurance carrier must reimburse the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the referred doctor may bill for a maximum of three body areas ...

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is \$385 adjusted per §134.210(b)(4) ...

Documentation indicates that the requester provided an impairment rating of a lower extremity. The adjusted reimbursement amount for the date of service in question is \$398.00.

The total allowable reimbursement for the services in question is \$863.00. The requester is seeking \$834.00. This amount 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 established that reimbursement is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that City of Austin must remit to William Defoyd, D.C. \$834.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 20, 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.