TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Continue Care Hospital

Respondent Name

BITCO General Insurance Corporation

MFDR Tracking Number

M4-22-1841-01

Insurance Carrier's Austin Representative

BOX 19 Flahive, Ogden & Latson

DWC Date Received

April 12, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2021 – July 31, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$17,500.00	Payment is hereby ordered to be made in accordance with the terms and conditions of the applicable contract.
August 1, 2021 – August 7, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$77,500.00	Payment is hereby ordered to be made in accordance with the terms and conditions of the applicable contract.
August 26, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$263.55	$0.00
September 1, 2021 – September 30, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$75,000.00	$0.00
October 1, 2021 – October 31, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$77,500.00	$0.00

November 1, 2021 – November 30, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$75,000.00	$0.00
December 1, 2021 – December 31, 2021	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$77,500.00	Payment is hereby ordered to be made in accordance with the terms and conditions of the applicable contract
January 1, 2022 – January 17, 2022	Long Term Acute Care Hospital (LTACH) Inpatient Hospital Stay	$42,500.00	$0.00
	Total	$359,671.82	Payment is hereby ordered to be made in accordance with the terms and conditions of the applicable contract.

Requester's Position

"Bitco has denied payment for the medical bills related to the necessary care provided to [injured employee] by CCH-Tyler. The denial reason provided by EOB is for the absence of preauthorization. Preauthorization was both written and verbal and covers [injured employee's] entire hospital stay. CorVel (UR agent for the Bitco), provided UA #[redacted], an approval number conforming with CMS rules regarding formatting… CCH-Tyler's position is that there was verbal preauthorization for the period August 26, 2021, through January 17, 2022".

Supplemental Position Received June 27, 2022

STATEMENT IN RESPONSE TO LETTER DATED MAY 16, 2022, FROM WHITE/ESPEY PLLC REGARDING CONTINUECARE HOSPITAL VS EMPOLYER GENERAL INSURANCE COMPANY

This Statement is submitted in response to the above reference letter following a review of information contained in said letter.

"We agree that as of May 16, 2022, the Respondent had paid to Tyler Continue Care Hospital("Hospital") the amount of $152,828.18 per the contract for care by the Hospital of…We disagree that the bills for dates of service July 24, 2021 – July 31, 2021(as well as the dates of service for August 1, 2021 through August 16, 2021) were not timely submitted…We further disagree with the statement that Requestor did not resubmit with medical bills with the required itemization".

Amount In Dispute: $359,671.82

Respondent's Position

"The Respondent actually paid $152,828.18 per the contract between the parties as the treatment was for inpatient hospital care. The Requestor is now seeking reimbursement in the amount of $359,671.82… Respondent correctly paid this matter. The bill for dates of service July 24, 2021-July 31, 2021 (as well as the dates of service for August 1, 2021 through August 16, 2021) was also denied as the Requestor did not timely submit a bill within 95 days of the date of service".

Response Submitted By: White Espey, PLLC

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. Texas Labor Code Section 408.027 sets out rules for timely submission of claims by health care providers.
3. Labor Code 408.0272 sets out exceptions to the timely filing of a medical bill.
4. 28 TAC Section 134.404 sets out the inpatient hospital facility fee guidelines.
5. 28 TAC Section 134.1 sets out medical reimbursement policies.
6. 28 TAC Section 133.2 sets out definitions for general rules for medical billing and processing.
7. 28 TAC Section 124.2 sets out the insurance carriers required notices and modes of payment.
8. 28 TAC Section 133.20 set out the health care providers billing procedures.
9. 28 TAC Section 102.4 sets out the general rules for non-division communications.
10. 28 TAC Section 141.1 sets out the guidelines for dispute resolution - benefit review conference.

Adjustment Reasons

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

1. 252 – Attachment required to adjudicate claim/service.
2. 26 – Expenses incurred prior to coverage.
3. 29 & RM2 – Time limit for filing claim/bill has expired.
4. N706 – Missing documentation.
5. 16 – Svc lacks info needed or has billing error(s).
6. 197 – Payment adjusted for absence of precert/preauth
7. W3 – Appeal/reconsideration
8. 214 – 75% of reasonable & customary charge
9. P5 – Based on payor reasonable/customary fees
10. RVW – Reviewed, no reduction determined
11. 524 – Recommended allowance per insurer decision
12. 97 – Charge included in another charge or service.

Issues

1. What is DWC considering in this medical fee dispute?
2. What rule applies for reimbursement of long-term acute care hospital services?
3. Did the requester obtain preauthorization for the dates of service in dispute?
4. What are the dates of service identified in each medical bill submitted for medical fee dispute resolution review?
5. Is the denial made by the insurance carrier supported for dates of service, July 24, 2021, through July 29, 2021?
6. Is the denial made by the insurance carrier supported for dates of service August 1, 2021, through August 26, 2021?
7. Is the denial made by the insurance carrier supported for dates of service September 1, 2021, through September 30, 2021?
8. Is the denial made by the insurance carrier supported for dates of service October 1, 2021, through October 29, 2021?
9. Is the denial made by the insurance carrier supported for dates of service November 1, 2021, through November 9, 2021?

10. Is the denial made by the insurance carrier supported for dates of service December 1, 2021, through December 14, 2021?

11. Is the denial made by the insurance carrier supported for dates of service January 1, 2022, through January 7, 2022?

12. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for Long-Term Acute Care Hospital (LTACH) services provided during the following dates:

   - July 24, 2021, through July 31, 2021
   - August 1, 2021, through August 31, 2021
   - September 1, 2021, through September 30, 2021
   - October 1, 2021, through October 31, 2021
   - November 1, 2021, through November 30, 2021
   - December 1, 2021, through December 31, 2021
   - January 1, 2022, through January 17, 2022

2. Long-Term Acute Care Hospitals are not reimbursed under the Medicare Inpatient Prospective Payment System (IPPS). Instead, they are subject to a separate payment methodology: Medicare's Long-Term Care Hospital Prospective Payment System. However, this system has not been adopted by DWC as a basis for reimbursement under any Texas fee guideline. As a result, reimbursement cannot be determined using the formula outlined in the Inpatient Hospital Fee Guideline under 28 TAC Section 134.404(f).
   A review of the submitted documentation supports the existence of a negotiated contract between the parties involved in this dispute. Accordingly, reimbursement is governed by the general medical reimbursement provisions outlined in 28 TAC Section 134.1(e), which states: "Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
   (1) the Division's fee guidelines;
   (2) a negotiated contract…"

   The contract provided by the parties includes the following agreement:
   "BITCO Insurance Companies agrees to pay TCCH $2,500 per diem for the duration of the approved stay within 45 days of receipt of a clean claim".

3. The dispute includes multiple copies of CorVel's utilization review determinations. DWC makes the following findings:

   - A preauthorization letter from CorVel dated July 22, 2021, approved a 25-day stay, effective from July 22, 2021, through August 15, 2021.
   - A subsequent letter dated August 20, 2021, approved an extension of seven days, effective from August 19, 2021, through August 25, 2021.
   - An additional letter dated January 19, 2022, approved a 25-day extension, effective from January 18, 2022, through February 12, 2022.

   The requester submitted multiple UB-04/CMS-1450 medical bills as part of the Medical Fee Dispute Resolution (MFDR) request. These bills include dates of service that were previously submitted to and reviewed by the insurance carrier before this MFDR request was filed. This dispute review addresses only the specific dates of service listed on each submitted medical bill, as outlined below:

Bill Date	Dates of service
November 1, 2021	July 24, 2021; July 26, 2021; July 27, 2021; July 29, 2021
November 19, 2021	August 1, 2021; August 2, 2021; August 3, 2021; August 4, 2021; August 7, 2021; August 26, 2021
November 19, 2021	September 1, 2021; September 3, 2021; September 4, 2021; September 20, 2021; September 23, 2021; September 29, 2021; September 30, 2021
November 30, 2021	October 1, 2021; October 2, 2021; October 6, 2021; October 29, 2021
December 3, 2021	November 1, 2021; November 3, 2021; November 9, 2021
January 7, 2022	December 1, 2021; December 7, 2021; December 10, 2021; December 14, 2021
February 18, 2022	January 1, 2022; January 4, 2022; January 7, 2022

4. The insurance carrier denied the dates of service from July 24, 2021, through July 29, 2021, citing the following denial reduction codes:

   - 252 – Attachment required to adjudicate claim/service.
   - 26 – Expenses incurred prior to coverage
   - 29 - RM2 – Time limit for filing claim/bill has expired.
   - N706 – Missing documentation
   - W3 – Appeal/reconsideration

28 TAC Section 133.20(b) requires that, except as provided in TLC Section 408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided". Additionally, TLC Section 408.027(a) states that "failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim".

According to 28 TAC Section 102.4(h), "unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission; or (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days falls on a Sunday or legal holiday, the date deemed sent shall be the next previous day that is not a Sunday or legal holiday".

A review of the medical bills finds sufficient documentation to support compliance with the 95-day billing requirement for the dates of service July 24, 2021; July 26, 2021; July 27, 2021; and July 29, 2021.

The insurance carrier also denied the disputed services using denial reduction code 26 - "Expenses incurred prior to coverage". A review of the medical documentation confirms that the injury date [redacted] precedes the disputed dates of service.

DWC Rule 28 TAC Section 133.307(d)(2)(H) requires that if a medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach a copy of any related Plain Language Notice (PLN) in accordance with Rule Section 124.2 (relating to carrier reporting and notification requirements).

Rule 28 TAC Section 124.2(h) requires notification to the division and claimant of any dispute regarding disability or extent of the injury using a plain language notice. These notices must provide a full and complete statement describing the carrier's action and the reasons for it. The statement must contain sufficient claim-specific substantive information to enable the employee or legal beneficiary to understand the carrier's position.

A review of the submitted information reveals no copies of a PLN-11 or PLN-1 notice issued in accordance with Rule Section 124.2, as required by Rule Section 133.307(d)(2)(H). Therefore, the insurance carrier's denial based on this reason is not supported.

Furthermore, the insurance carrier denied the services in dispute with denial reduction codes N706 -"Missing Documentation" and 252 - "Attachment required to adjudicate claim/service". The carrier failed to provide sufficient documentation to substantiate these

denial reasons. Consequently, reimbursement is due to the requester for the disputed services. Accordingly, reimbursement is due for the dates of service July 24, 2021; July 26, 2021; July 27, 2021; and July 29, 2021, in accordance with the terms and conditions of the applicable contract.

5. The insurance carrier denied the claims for dates of service August 1, 2021; August 2, 2021; August 3, 2021; August 4, 2021; August 7, 2021; and August 26, 2021, citing the following adjustment reason codes:

   - 252 – Attachment required to adjudicate claim/service
   - 16 – Svc lacks info needed or has billing error(s).
   - 197 – Payment adjusted for absence of precert/preauth
   - W3 – Appeal/reconsideration
   - 29 – Time limit for filing claim/bill has expired.
   - N706 – Missing documentation

   Texas Labor Code Section 408.027(a) provides, in relevant part, that failure by a health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim.

   A review of the submitted medical bills confirms that the requester filed the claims within the required 95-day timeframe. Accordingly, the insurance carrier's denial based on untimely filing is not supported.

   DWC next addresses denial reason code 197, which pertains to the absence of pre-certification or preauthorization.

   CorVel's preauthorization letter dated July 22, 2021, reflects approval for a 25-day stay effective July 22, 2021, through August 15, 2021. Therefore, for the dates of service August 1, 2021; August 2, 2021; August 3, 2021; August 4, 2021; and August 7, 2021, DWC finds that the insurance carrier's denial based on lack of preauthorization is not supported.

   The insurance carrier also denied the disputed services under denial codes 252 (attachment required), N706 (missing documentation), and 16 (insufficient information or billing errors). However, the carrier did not provide adequate documentation to substantiate these denial reasons. Accordingly, reimbursement is due for the dates of service August 1, 2021; August 2, 2021; August 3, 2021; August 4, 2021; and August 7, 2021. The insurance carrier is ordered to issue payment in accordance with the terms and conditions of the applicable contract.

   With respect to the date of service August 26, 2021, DWC finds that the requester did not submit sufficient documentation to establish that preauthorization was obtained. Therefore, reimbursement for this date of service is not recommended.

6. The insurance carrier denied the claims for the dates of service September 1, 2021; September 3, 2021; September 4, 2021; September 20, 2021; September 23, 2021; September 29, 2021; and September 30, 2021, citing the following adjustment reason codes:

   - 252 – Attachment required to adjudicate claim/service
   - 16 – Svc lacks info needed or has billing error(s).
   - 197 – Payment adjusted for absence of precert/preauth
   - W3 – Appeal/reconsideration
   - N706 – Missing documentation

   A review of the preauthorization letters finds that the requester submitted insufficient documentation to establish that preauthorization was obtained for the disputed services.

   The requester contends that the services were rendered on an emergency basis. DWC makes the following findings:

   Under 28 TAC Section 133.2(5)(A)(i)–(ii), a medical emergency is defined as the sudden onset of a medical condition presenting with acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to place the patient's health or bodily functions in serious jeopardy, or result in serious dysfunction of any body organ or part.

   DWC finds that the requester did not submit a position statement explaining how the healthcare services provided on the disputed dates meet the definition of emergency care. Neither the position statement nor the supporting documentation provides sufficient evidence or rationale to support a determination that the services constituted emergency care.

   Accordingly, DWC concludes that the provider has not met its burden of proof to establish that the disputed dates of service qualify as emergency care. Because preauthorization was required and was not obtained, the requester is not entitled to reimbursement for the dates of service September 1, 2021; September 3, 2021; September 4, 2021; September 20, 2021; September 23, 2021; September 29, 2021; and September 30, 2021.

7. The insurance carrier denied the claims for dates of service October 1, 2021; October 2, 2021; October 6, 2021; and October 29, 2021, citing denial code 197 – Payment adjusted due to absence of precertification/preauthorization.

   A review of the preauthorization letters indicates that the requester submitted insufficient documentation to demonstrate that preauthorization was obtained for these dates of service.

   The requester contends that these services were provided as a medical emergency. DWC makes the following findings:

Under 28 TAC Section 133.2(5)(A)(i)–(ii), a medical emergency is defined as the sudden onset of a medical condition presenting with acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to place the patient's health or bodily functions in serious jeopardy, or result in serious dysfunction of any body organ or part.

DWC finds that the requester did not submit a position statement explaining how the healthcare provided on the disputed dates qualifies as emergency care. Neither the statement nor the supporting documentation provides sufficient evidence or explanation to establish that the services rendered were emergency care.

Accordingly, DWC concludes that the requester has not met the burden of proof to demonstrate that the disputed dates of service were emergency care. Because preauthorization was required but not obtained, the requester is not entitled to reimbursement for the dates of service October 1, 2021; October 2, 2021; October 6, 2021; and October 29, 2021.

8. The insurance carrier denied reimbursement for the dates of service November 1, 2021; November 3, 2021; and November 9, 2021, citing denial code 197: "Payment adjusted for absence of precertification/preauthorization."

   A review of the preauthorization letters confirms that the requester did not provide sufficient documentation to demonstrate that preauthorization was obtained for the disputed services.

   The requester asserted that the services were rendered due to a medical emergency. DWC makes the following findings:

   Under 28 TAC Section 133.2(5)(A)(i)–(ii), a medical emergency is defined as the sudden onset of a medical condition presenting with acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to place the patient's health or bodily functions in serious jeopardy, or result in serious dysfunction of any body organ or part.

   DWC finds that the requester did not submit a position statement explaining how the healthcare provided on the disputed dates meets the definition of emergency care. Moreover, the supporting documentation does not provide sufficient evidence to establish that the services were rendered in response to a medical emergency.

   Accordingly, DWC concludes that the provider has not met the burden of proof to demonstrate that the disputed services qualify as emergency care. Because preauthorization was required and was not obtained, the requester is not entitled to reimbursement for the dates of service November 1, 2021; November 3, 2021; and November 9, 2021.

9. The insurance carrier issued payments totaling $82,828.18 for the dates of service; December 1, 2021; December 7, 2021; December 10, 2021; and December 14, 2021. The disputed charges were subject to the following reduction codes:

   - 214 – 75% of reasonable & customary charge.
   - RVW – Reviewed no reduction determined.
   - P5 – Based on payor reasonable/customary fees.

   DWC finds that the requester billed a total of $110,437.57 for services rendered between December 1, 2021, and December 31, 2021. The insurance carrier paid $82,828.18, and the requester is seeking an additional $77,500.00.

   DWC determines that the requester is entitled to reimbursement for the disputed services. The insurance carrier is ordered to issue any additional payment due in accordance with the terms and conditions of the applicable contract.

10. The insurance carrier denied reimbursement for the dates of service January 1, 2022, through January 31, 2022, citing the following adjustment reason codes:

    - 524 – Recommended allowance per insurer determination
    - P5 – Based on payer reasonable and customary fees
    - 97 – Charge included in another service or payment

    In the bill remarks, the carrier stated: "Preauthorization is on file for an inpatient LTACH admission beginning January 18, 2022. Only 13 days were authorized. Reimbursement per letter of agreement for 13 days is $32,500". However, the documentation does not include information confirming that payment was issued or applied to the disputed claim.

    The carrier also denied the services as "included in another charge"; however, no supporting documentation was provided to substantiate bundling or duplicate payment, nor was evidence submitted demonstrating that services rendered at the LTACH during the disputed period were included in an alternate payment. Accordingly, this denial rationale is not supported.

    A review of the UB-04 and accompanying EOBs reflects that the billed and adjudicated services correspond to dates January 1, 4, and 7, 2022. As this matter involves LTACH inpatient services subject to prospective payment methodology, reimbursement is governed by the authorized inpatient stay and applicable coverage criteria rather than individual line-item service dates. The record reflects that authorization was provided for a 13-day inpatient LTACH stay beginning January 18, 2022. However, no documentation was submitted to establish that the disputed billed and audited dates of January 1, 4, and 7, 2022 were included within the authorized inpatient admission period or otherwise separately authorized.

Accordingly, DWC finds that the disputed dates of service are not supported for reimbursement, as preauthorization for LTACH inpatient services was not obtained for those dates. Based on the documentation submitted, reimbursement is not recommended for the disputed services.

11. DWC makes the following decisions:

(1) A review of the medical billing documentation confirms that the 95-day billing requirement was met for the following dates of service: July 24, 2021; July 26, 2021; July 27, 2021; and July 29, 2021. Accordingly, the insurance carrier is ordered to issue payment in accordance with the terms and conditions of the applicable contract for these dates.

(2) For the dates of service August 1, 2021; August 2, 2021; August 3, 2021; August 4, 2021; and August 7, 2021, DWC finds that the insurance carrier's denial based on lack of preauthorization is not supported. The requester is therefore entitled to reimbursement, and the insurance carrier is ordered to issue payment in accordance with the terms and conditions of the applicable contract.

(3) For the date of service August 26, 2021, DWC finds that the requester submitted insufficient documentation to demonstrate that preauthorization was obtained. DWC finds that preauthorization was required but not obtained; therefore, reimbursement for these dates is not warranted.

(4) For the dates of service September 1, 2021; September 3, 2021; September 4, 2021; September 20, 2021; September 23, 2021; September 29, 2021; and September 30, 2021, DWC concludes that the provider did not meet the burden of proof to establish that the services rendered qualified as emergency care. DWC finds that preauthorization was required but not obtained; therefore, reimbursement for these dates is not warranted.

(5) For the dates of service October 1, 2021; October 2, 2021; October 6, 2021; and October 29, 2021, DWC similarly finds that the requester did not demonstrate that the services constituted emergency care. DWC finds that preauthorization was required but not obtained; therefore, reimbursement for these dates is not warranted.

(6) For dates of service from November 1, 2021, through November 30, 2021, including November 1, 2021; November 3, 2021; and November 9, 2021, DWC finds that the requester did not demonstrate that the services constituted emergency care. DWC finds that preauthorization was required but not obtained; therefore, reimbursement for these dates is not warranted.

(7) For dates of service December 1, 2021, through December 31, 2021. The insurance carrier is hereby ordered to issue payment in accordance with the terms and conditions of the applicable contract.

(8) For the dates of service January 1, 2022, through January 7, 2022, DWC finds that preauthorization was required but not obtained; therefore, reimbursement for these dates is not warranted.

12. Based on the above findings, DWC determines that:
    The requester has not established entitlement to reimbursement for the following dates of service: August 26, 2021; September 1, 2021, through September 30, 2021; October 1, 2021, October 31, 2021; November 1, 2021, through November 30, 2021; and January 1, 2022, through January 17, 2022. Accordingly, reimbursement for these dates is not recommended.

    DWC further determines that the requester is entitled to reimbursement for the following dates of service: July 24, 2021, through July 31, 2021; August 1, 2021, through August 7, 2021; and December 1, 2021, through December 31, 2021. The insurance carrier is directed to issue payment in accordance with the terms and conditions of the applicable contract for the approved dates of service identified in this decision.

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 additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is hereby ORDERED that BITCO General Insurance Corporation shall remit payment to Continue Care Hospital in strict accordance with the terms and conditions of the applicable contract. Such payment shall include all amounts determined to be due under the contract, together with any applicable accrued interest. Payment shall be issued within thirty (30) days of receipt of this Order, in compliance with 28 TAC Section 134.130.

Authorized Signatures

		May 22, 2026
Signature	Medical Fee Dispute Resolution Officer	Date
		May 22, 2026
Signature	Deputy Commissioner of Operations	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.