



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Rio Occupational Institute

Respondent Name

Arch Indemnity Insurance Co

MFDR Tracking Number

M4-25-0873-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

December 17, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 8, 2024	80305 59	\$35.00	\$0.00
July 8, 2024	99080 73	\$20.00	\$0.00
July 8, 2024	99204	\$355.00	\$0.00
July 8, 2024	73560	\$100.00	\$0.00
July 12, 2024	99213	\$160.00	\$0.00
July 12, 2024	99080 73	\$20.00	\$0.00
July 19, 2024	99213	\$160.00	\$0.00
July 19, 2024	99080 73	\$20.00	\$0.00
Total		\$870.00	\$0.00

Requestor's Position

"I have attached a copy of the email from supervisor Jorge Castro dated November 12, 2024 informing the provider that this claim should go to Gallagher Bassett Insurance."

Amount in Dispute: \$870.00

Respondent's Position

The Austin carrier representative for Arch Indemnity Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on December 24, 2024.

Per 28 TAC §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the 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 §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 resolving medical fee disputes.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission.

Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes.

- 00663 – Reimbursement has been calculated based on the state guidelines.
- 90096 – The time limit for filing has expired.
- 29 – The time limit has expired
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Was the claim originally submitted to the employer?

Findings

1. The requestor is seeking reimbursement professional medical services rendered in July of 2024. The insurance carrier denied the disputed services as not submitted timely. The information submitted with this request for MFDR include an email dated November 12, 2024 from the injured workers’ employer that states in pertinent part, “This invoice is a workers compensation claim.”

DWC Rule 28 TAC §133.20 (j)(1)C states, “The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill or bills. Such billing is subject to the following:

(1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(C) medical dispute resolution as provided by Labor Code §413.031.

DWC finds the greater weight of evidence supports the disputed charges were originally submitted to the employer. As such, the requestor has waived their right to MFDR.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor 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 requestor is entitled to additional \$0.00 reimbursement for the disputed services.

Authorized Signature

		March 21, 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.texas.gov.