



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Dallas Medical Center

**Respondent Name**

Zurich American Insurance Co

**MFDR Tracking Number**

M4-25-1795-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 3, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16, 2023	Lumbar injections	\$20,774.85	\$0.00

### Requester's Position

The requester did not submit a position statement with this request for MFDR. They included a document titled, "Request for Reconsideration" dated November 21, 2024 that states, "...This claim was submitted twice within timely filing..."

**Amount in Dispute:** \$20,774.85

### Respondent's Position

"...However, the carrier has reprocessed the provider's medical bill. Once we received the EOR, we will forward it to the medical review decision and to the provider. We have been told the EOR will recommend payment of \$2,484.15 plus interest. It is the carrier's position that the medical fee guidelines provide for the payment of \$2,484.15 plus interest."

### Supplemental response submitted May 12, 2025

"Carrier has previously responded to this dispute on April 22, 2025. We are attaching a copy of the Carrier's EOR dated April 10, 2025 that recommends payment of \$2,484.15."

## **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.

### Denial Reasons

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

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 2008 – Additional payment made on appeal/reconsideration
- 300 – An allowance has been made for a bilateral procedure
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 947 – Upheld. No additional allowance has been recommended.
- 948 – Re-reviewed at providers request with additional information and documentation additional payment suggested.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Bill is a reconsideration or appeal.

### Issues

1. Did the requester waive the right to medical fee dispute resolution?

## Findings

1. The requester is seeking payment for outpatient hospital services rendered in October of 2023. DWC Rule 28 TAC §133.307(c)(1) states:

"Timeliness. A requester shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.

(A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requester receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requester received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The dates of the service in dispute are October 16, 2023. The request for medical dispute resolution was received at the Division on April 3, 2025.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requester has waived their right to MFDR for dates of service in dispute.

## 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 \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

August 15, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).