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

General Information

Requester Name

Ward Memorial Hospital

Respondent Name

Carolina Casualty Insurance

MFDR Tracking Number

M4-25-2025-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

April 24, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 2, 2024 through October 31, 2024	Physical Therapy	$5,760.00	$0.00
	Total	$5,760.00	$0.00

Requester's Position

"On 4/3/2025, I emailed Medata for bill status on the reconsideration. They responded & sent me another EOR stating they need the CAH rates & that the claim was denied for no authorization. Medata are the ones who approved (injured worker) Physical Therapy & I sent the CAH rates with my reconsideration."

Amount In Dispute: $5,760.00

Respondent's Position

The Austin carrier representative for Carolina Casualty Insurance is Downs Stanford PC. The representative was notified of this medical fee dispute on May 7, 2025.

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 133.10 sets out the requirements for a complete medical bill.
3. 28 TAC Section 133.20 sets out the requirements for medical bill submission.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- @G (W3) – No additional reimbursement allowed after review of appeal/reconsideration.
- EL(P12) – Per CMS guidelines, Critical Access Hospitals are paid at reasonable costs. Please submit you facility's CAR rates for accurate reimbursement of these charges.
- EXPA – Service exceeds pre-authorized approval. Please provide documentation and/or additional authorization for the service not included in the original documentation.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the requester support submission of medical bill in accordance with applicable DWC requirements?

Findings

1. The requester seeks reimbursement of $5,760.00 for physical therapy services provided from October 2, 2024, through October 31, 2024. The insurance carrier denied the services in their entirety. DWC will review the submitted documentation for compliance with applicable workers' compensation rules and fee guidelines.
2. The applicable billing requirements are set forth in 28 TAC Section 133.10(c)(2)(C), which provides that a complete institutional medical bill related must include the required data elements, including the correct type of bill (UB-04/Field 04).

Additionally, 28 TAC Section 133.20(c) states that a health care provider must include correct billing codes when submitting medical bills.

The submitted bill reported NPI [redacted]. A search of the National Plan and Provider Enumeration System (NPPES) registry indicates that this NPI is registered as a General Acute Care Hospital/Critical Access Hospital provider type.

The submitted medical bill was billed using Type of Bill 131 (Outpatient Hospital). Based on the provider classification associated with the reported NPI, the bill type submitted is not valid for the services billed. Therefore, reimbursement is not 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 reimbursement is due.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 25, 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.