



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Methodist Health System

Respondent Name

Hartford Underwriters Insurance Co.

MFDR Tracking Number

M4-25-2161-01

Carrier's Austin Representative

Box Number 47

Date Received

May 8, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 21, 2023	emergency visit	\$1,310.59	\$0.00

Requestor's Position

"Requesting review of compensability."

Amount in Dispute: \$1,310.59

Respondent's Position

"The original bill for dos 8/21 /23 was received on 9/19/23 ... and denied as under investigation on 9/25/23. Bill was reprocessed and denied as not approved per adjuster's instructions on 5/23/25."

Response submitted by: The Hartford

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](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 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:

- CONT - We are in receipt of your bill for services. payment is being withheld pending further investigation of compensability or treatment. If you require additional information regarding this bill decision, contact the claim handler.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 18 -EXACT DUPLICATE CLAIM/SERVICE.
- 247 -A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
- 95 - NON-COVERED CHARGES.
- W3 - BILL IS A RECONSIDERATION OR APPEAL.
- 2005 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
- NABA - REIMBURSEMENT IS BEING WITHHELD AS THE TREATING DOCTOR AND/OR SERVICES RENDERED WERE NOT APPROVED BASED UPON HANDLER REVIEW. IF YOU REQUIRE ADDITIONAL INFORMATION REGARDING THIS BILL DECISION, CONTACT THE CLAIM HANDLER.

Issues

1. Is the Insurance Carrier's denial of compensability, liability or extent of injury supported?
2. Has the requestor waived their right to medical fee dispute resolution?

Findings

1. The requestor seeks reimbursement for emergency medical services rendered on August 21, 2023. The medical services in dispute were denied by the workers' compensation carrier due to an unresolved compensability, liability or extent of injury issue.

28 TAC §133.305(b) states that if a dispute over the compensability, liability or extent of injury exists for the same service for which there is a medical fee dispute, the dispute regarding the

extent of injury shall be resolved prior to the submission of a medical fee dispute.

The review of the submitted documentation indicates that the respondent failed to provide adequate proof to DWC demonstrating that it filed a Plain Language Notice (PLN) concerning the disputed conditions, as mandated by §133.307 (d)(2)(H). Furthermore, the respondent did not offer sufficient information to Medical Fee Dispute Resolution (MFDR) to establish that the PLN was ever presented to the requestor or that the requestor was made aware of the PLN prior to the submission of the request for medical fee dispute resolution with DWC.

Because the service in dispute does not contain an unresolved compensability, liability or extent of injury issue, this matter is eligible for adjudication pursuant to the applicable rules and guidelines.

2. The requestor seeks payment in the amount of \$1,310.59, for emergency medical services provided on August 21, 2023. The medical fee dispute was received by the Division on May 8, 2025.

Per 28 TAC §133.307 (c)(1), the requestor must request medical fee dispute resolution within one year from the date of service, unless a related compensability, extent of injury, or liability dispute exists; or a dispute regarding medical necessity has been filed. If these exceptions apply, a request for medical fee dispute resolution must be filed within 60 days after the date the requestor receives the final decision.

DWC received the medical fee dispute resolution request on May 8, 2025. This is more than one year after the date of service August 21, 2023. A review of the documentation submitted finds no evidence to support that an exception applied to this date of service.

A review of the submitted documentation finds that the disputed service(s) do not involve issues identified in 28 TAC §133.307 (c) (1) (B). DWC concludes that the requestor has failed to timely file this dispute with the Division; consequently, the requestor has waived the right to medical fee dispute resolution.

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 requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 29, 2025
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. The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, 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 the Division. **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.