TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requester Name**
North Central Baptist Medical Center

**Respondent Name**
University Health System

**MFDR Tracking Number**
M4-25-2243-01

**Carrier's Austin Representative**
Box Number 16

**DWC Date Received**
May 14, 2025

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| October 11, 2022 through October 14, 2022 | 0250 | $2994.00 | $0.00 |
| | 0278 | $287571.18 | $0.00 |
| | 0300 | $5040.00 | $0.00 |
| | 0350 | $13954.00 | $0.00 |
| | 0360 | $94895.00 | $0.00 |
| | 0370 | $17904.00 | $0.00 |
| | 0420 | $1028.00 | $0.00 |
| | 0424 | $666.00 | $0.00 |
| | 0430 | $1000.00 | $0.00 |
| | 0434 | $666.00 | $0.00 |
| | 0636 | $2788.00 | $0.00 |
| | 0710 | $41744.00 | $0.00 |

| | | | |
|---|---|---|---|
| | WC ADJUSTMENT | -442982.18 | $0.00 |
| | **Total** | $27,268.00 | $0.00 |

## Requester's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed ANCHOR, but the bill was not paid/reimbursed appropriately."

**Amount in Dispute:** $27,268.00

## Respondent's Position

The Austin carrier representative for University Health System is Ray Pena McChristian. The representative was notified of this medical fee dispute on May 20, 2025.

Per 28 Texas Administrative Code §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 (TLC) §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 payment for the disputed services with the following claim adjustment codes:

- 18 – Exact duplicate claim/service.
- 306 – Billing is a duplicate of other services performed on same day.
- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec 408.02, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Is the Requester eligible for DWC medical fee dispute resolution for the services in question?

Findings

1. The requester is seeking reimbursement for inpatient hospital services provided from October 11 – 14, 2022. According to 28 Texas Administrative Code (TAC) §133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the same provision.

   Specifically, 28 TAC §133.307(c)(1)(B) allows for a later filing if one of the following conditions applies:

   (i) A related dispute concerning compensability, extent of injury, or liability under Labor Code Chapter 410 has been filed. In such cases, the medical fee dispute must be submitted within 60 days after the requester receives the final decision on compensability, extent of injury, or liability, including all appeals.

   (ii) A dispute regarding medical necessity has been filed. Here, the medical fee dispute must be filed within 60 days after the requester receives the final decision on medical necessity, including all appeals, for the specific health care services in question that were previously denied by the insurance carrier on the basis of medical necessity.

   (iii) The dispute arises from a refund notice issued following a division audit or review. In this situation, the medical fee dispute must be filed within 60 days after the requester receives the refund notice.

In this case, inpatient hospital services were provided from October 11 -14th, 2022. The Division received the MFDR request on May 14, 2025, which is more than one year after the date(s) of service. Upon review of the documentation provided, there is no indication that the dispute falls within any of the exceptions described in 28 TAC §133.307(c)(1)(B).

Therefore, the Division concludes that the requester failed to file the MFDR request within the required timeframe and has consequently waived the right to pursue Medical Fee Dispute Resolution for this claim

**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.

The Division finds the requester has not established that reimbursement is due.

## Order

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

**Authorized Signature**

| | | |
|---|---|---|
| | | July 31, 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. 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 electronico CompConnection@tdi.texas.gov.