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
Methodist Health Systems

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-25-2308-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
May 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 11, 2024	Minor procedure	$251.90	$0.00

Requester's Position

"Requesting review of authorization denial."

Amount in Dispute: $251.90

Respondent's Position

The Austin carrier representative for Texas Mutual is Texas Mutual. The representative was notified of this medical fee dispute on May 22, 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) §133.20 sets out the procedures for submission of a medical bill.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. The Texas Labor Code (TLC) §408.027 sets out the rules for timely submission of claims by health care providers.
4. TLC §408.0272 sets out the exceptions to the timely filing of a medical bill.
5. 28 TAC §141.1 sets out the guidelines for dispute resolution—benefit review conference.

Denial Reasons

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

- 714 – Accurate coding is essential for reimbursement CPT billed incorrectly services are not reimbursable as billed.
- CAC-W3/350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-138 – Appeal procedures not followed, or time limits not met.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-29 – The time limit for filing has expired.
- DC4 – No additional reimbursement allowed after reconsideration.
- 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
- 879 – Rule 133.250(B) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

Issues

1. Is the requester entitled to reimbursement for the disputed service(s)?

Findings

1. The requester is seeking reimbursement in the amount of $251.90 for outpatient wound care visit provided on June 11, 2024. A corrected bill was submitted as a reconsideration and received by the insurance carrier in March of 2025. The insurance carrier originally denied the claim as the submitted code was not valid on the date of service. The insurance carrier denied the corrected claim, citing untimely submission of the medical bills.

   According to 28 Texas Administrative Code (TAC) §133.20(b) and Texas Labor Code (TLC) §408.027(a), medical bills must be submitted no later than 95 days after the date the services are provided. Exceptions to this rule are outlined in TLC §408.0272(b), which allows for late submission if the provider billed:

   - An insurer that issued a group accident and health insurance policy under which the injured employee was covered;
   - A health maintenance organization that issued evidence of coverage for the injured employee;
   - A workers' compensation insurance carrier other than the one liable for payment of benefits; or
   - If the commissioner determines that a catastrophic event substantially interferes with the provider's normal business operations.

   TLC §408.0272(d) also provides that the submission deadline may be extended by mutual agreement of the parties.

   Upon review, the Division of Workers' Compensation (DWC) found insufficient evidence that the corrected medical bill was submitted to the insurance carrier within 95 days after the service date. There was also no supporting documentation indicating that the bills qualified for any of the stated exceptions, nor any evidence of an agreement between the parties to extend the filing deadline.

   Based on the evidence presented, the requester did not demonstrate timely submission or eligibility under an exception. Therefore, the DWC concludes that the requester is not entitled to reimbursement for the services in dispute.

Conclusion

The resolution of this medical fee dispute is based on the evidence submitted by both the requester and the respondent. While not every piece of evidence is discussed in detail, all materials were reviewed and considered.

The DWC finds that the requester has not established entitlement to reimbursement.

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

		July 31, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party involved in this medical fee dispute has the right to request a review of this decision under 28 TAC §133.307, which applies to disputes filed on or after June 1, 2012.

To initiate a request for review, the party must complete and submit *DWC Form-045M, Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD),* in accordance with the instructions set forth on the form. This form may be accessed at www.tdi.texas.gov/forms/form20numeric.html.

The completed request must be submitted to the Texas Department of Insurance, Division of Workers' Compensation (DWC), within twenty (20) days of receipt of this decision. Submissions may be made via facsimile, postal mail, or personal delivery, using the contact information provided on the form or that of the appropriate DWC field office managing the claim. Timely submission is essential to ensure that the request is considered and processed appropriately.

The party requesting a review must also send a copy of the request to all other parties involved in the dispute at the same time as it is submitted to the Division of Workers' Compensation (DWC). The request must also include a copy of the Medical Fee Dispute Resolution Findings and Decision, along with any other required documents listed in 28 TAC §141.1(d).

For any inquiries regarding *DWC Form-045M*, please contact CompConnection at 1-800-252-7031 (option 3) or via email at CompConnection@tdi.texas.gov.