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

Requestor Name
METHODIST HEALTH SYSTEMS

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-25-2313-01

Carrier's Austin Representative
Box Number 19

Date Received
May 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 1, 2024	Hospital Outpatient	$5,591.93	$0.00

Requestor's Position

"Requesting review for timely filing. Originally billed to BlueCross."

Amount in Dispute: $5,591.93

Respondent's Position

"In accordance with Texas Administrative Code Rule 133.307, this request for payment has been denied. Specifically, per Rule 133.307(c)(2): "(A) A request for MFDR 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."

Response Submitted by: TASB Risk Fund

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:

- X29, 29 – The time limit for filing has expired.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- ART – TX Rule 133.250(B) a health care provider shall submit a request for reconsideration no later than 10 months from the date of service.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Note: MFDR M4-5-2313-01 Standing on denial as no reconsideration was submitted and past MFDR timeline. §133.250.(a)(b) states, If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing. The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

Issues

1. Has the requestor waived their right to medical fee dispute resolution?

Findings

1. The requestor seeks payment in the amount of $5,591.93, for medical services provided on January 1, 2024.

   28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request

was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

The service in question was performed on January 1, 2024. The medical fee dispute was received by the Division on May 20, 2025. This date is more than a year following the in-question date(s) of service.

28 TAC §133.307 (c) (1) (A) states, "A request for MFDR 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."

A review of the submitted documentation finds that the disputed service(s) does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division 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.

The Division 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

[redacted]		June 12, 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.