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 SYSTEM

Respondent Name
TASB RISK MANAGEMENT FUND

MFDR Tracking Number
M4-25-2314-01

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
December 31, 2023	Hospital Outpatient	$345.71	$0.00

Requestor's Position

"Requesting a review for timely filing. Originally billed to Blue Cross."

Amount in Dispute: $345.71

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. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed no later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability.' The dispute issues in this case were required to be resolved before the MFDR was filed, as mandated by Rule 133.307. Our review confirms that his procedural requirement was not me and therefore, the denial is upheld."

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:

- 29, X29 – 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

Issues

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

Findings

1. The requestor is seeking reimbursement in the amount of $345.71 for medical services provided on December 31, 2023. The Division received the medical fee dispute on May 20, 2025.

   In accordance with 28 TAC §133.307(c)(1), a request for medical fee dispute resolution must be filed within one year of the date of service, unless there is a related dispute involving compensability, extent of injury, liability, or medical necessity. If one of these exceptions applies, the request must be filed within 60 days of receiving the final decision related to that issue.

   The Division received this request on May 20, 2025, which is more than one year after the date of service, December 31, 2023. Upon review, the Division found no supporting documentation to indicate that any of the exceptions outlined in 28 TAC §133.307(c)(1)(B) apply to this case.

Therefore, the Division has determined that the requestor failed to file the medical fee dispute resolution request in a timely manner. As a result, the requestor has waived the right to pursue medical fee dispute resolution

Conclusion

The outcome of this medical dispute is based on the evidence submitted by both the requestor and the respondent during the adjudication process. Although not all the evidence may be specifically addressed, all submitted evidence was reviewed and considered in reaching the final decision.

The Division concludes that the requestor has not demonstrated entitlement to reimbursement

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 6, 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.