



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

VHS Harlingen Hospital

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-25-2731-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

June 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 31, 2024	0250	\$341.00	\$0.00
May 31, 2024	0300	\$2236.00	\$0.00
May 31, 2024	0360	\$34537.00	\$0.00
May 31, 2024	0370	\$6926.00	\$0.00
May 31, 2024	0420	\$693.00	\$0.00
May 31, 2024	0424	\$1582.00	\$0.00
May 31, 2024	0636	\$2962.00	\$0.00
May 31, 2024	0710	\$10723.00	\$0.00
May 31, 2024	0730	\$1353.00	\$0.00
	WC ADJUSTMENTS	-\$55544.60	\$0.00
	Total	\$5,808.40	\$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 BROADSPIRE, but the bill was denied for timely filing. However, this was due to the member providing WellMed to the Hospital. Under Texas Labor Code §408.0272 a health care provider does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if the claim was erroneously filed for reimbursement with a workers' compensation carrier other than the carrier liable for payments of benefits. In this case, WellMed information was provided to the Hospital and billed. As such, BROADSPIRE is responsible for the proper payment of this medically necessary treatment directly related to the patient's work-related injury."

Amount in Dispute: \$5,808.40

Respondent's Position

Broadspire on behalf of Zurich American Insurance Co the above captioned Medical Fee Dispute Resolution. The bill has been denied as the service was not preauthorized. We have attached the EOB."

Response Submitted by: Broadspire

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.

Denial Reasons

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

- D10 – The time limit for filing has expired.
- D49 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations for payment policies.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- D00 – Based on further review, no additional allowance is warranted.

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 outpatient hospital services provided on May 31, 2024. 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, outpatient hospital services were provided on May 31, 2024. The Division received the MFDR request on June 30, 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 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

Signature

Medical Fee Dispute Resolution Officer

July 21, 2025

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.