



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

METHODIST HEALTH SYSTEMS

**Respondent Name**

SERVICE AMERICAN INDEMNITY CO

**MFDR Tracking Number**

M4-24-2851-01

**Carrier's Austin Representative**

Box Number 60

**Date Received**

July 9, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 30, 2023	Emergency room visit	\$2,750.04	\$0.00

### Requester's Position

"REQUESTING REVIEW OF TIMELY FILING"

**Amount in Dispute:** \$2,750.04

### Respondent's Position

"The previous Timely Filing denial will be upheld under SATX-18057. The additional supporting documentation was not received until 04/08/2025."

**Response Submitted by:** Enlyte

# 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 reduced or denied payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 16 – Documentation does not support that services rendered were medically necessary.
- M127 – Missing patient medical record for this service
- MA27 – Missing/incomplete/invalid entitlement number or name shown on the claim
- MA30 – Missing/incomplete/invalid type of bill
- N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information
- 16 – Claim/service lacks information or has submission/billing error(s)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 241 – Not documented
- 29 – The time limit for filing has expired
- 350 – Bill has been identified as a request for reconsideration or appeal
- 351 – No additional reimbursement allowed after review of appeal/reconsideration
- 375 – Please see Special \*NOTE\* below
- 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
- X29 – The time limit for filing has expired

## **Issues**

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

## **Findings**

1. The Requester seeks payment in the amount of \$2,750.04, for medical services provided on November 30, 2023.

28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A Requester 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 November 30, 2023. The medical fee dispute was received by the Division on July 9, 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 Requester has failed to timely file this dispute with the Division; consequently, the Requester 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 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 of 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**

  
\_\_\_\_\_  
Signature Medical Fee Dispute Resolution Officer Date July 30, 2025

### **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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).