



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

METHODIST HEALTH SYSTEM

**Respondent Name**

CITY OF RICHARDSON

**MFDR Tracking Number**

M4-25-2856-01

**Carrier's Austin Representative**

Box Number 44

**Date Received**

July 10, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 18, 2023	Emergency room visit	\$475.71	\$0.00
<b>Total</b>		\$475.71	\$0.00

### Requester's Position

"Requesting review of unpaid date of service. Payer stated that it denied as bundled services but refuses to provide the eob."

**Amount in Dispute:** \$475.71

### Respondent's Position

The Austin carrier representative for City of Richardson is White Espey PLLC. This representative was notified of the medical fee dispute on July 11, 2025.

Pursuant to 28 Texas Administrative Code §133.307(d)(1), if the Division of Workers' Compensation (DWC) does not receive a response within 14 calendar days of the dispute notification, it may base its decision on the information available.

As of the date of this decision, no response has been received from the insurance carrier or its representative. Accordingly, this decision is based solely on the available documentation."

## 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**

Neither party submitted an Explanation of Benefits (EOB) providing the reasons for the [reduction or denial] of payment for the disputed services.

### **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 Emergency room visit services provided on March 18, 2023. 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 based on 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, Emergency room visit was provided on March 18, 2023. The Division received the MFDR request on July 10, 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).

The Division finds the requester has not established that reimbursement is due.

### Conclusion

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.

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.

## **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**

	August 27, 2025
Signature	Date
Medical Fee Dispute Resolution Officer	

## **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).