



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

St. Lukes Regional Medical Center

Respondent Name

Chubb Indemnity Insurance Co

MFDR Tracking Number

M4-25-2901-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

July 15, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 24, 2024	110	\$2,092.52	\$0.00
October 24, 2024	250	\$492.19	\$0.00
October 24, 2024	260	\$371.06	\$0.00
October 24, 2024	270	\$205.36	\$0.00
October 24, 2024	272	\$148.18	\$0.00
October 24, 2024	278	\$5,239.77	\$0.00
October 24, 2024	300	\$17.03	\$0.00
October 24, 2024	301	\$157.67	\$0.00
October 24, 2024	305	\$35.52	\$0.00
October 24, 2024	320	\$344.54	\$0.00
October 24, 2024	350	\$1,977.67	\$0.00
October 24, 2024	360	\$9,506.84	\$0.00

October 24, 2024	370	\$1,773.77	\$0.00
October 24, 2024	420	\$115.82	\$0.00
October 24, 2024	424	\$60.10	\$0.00
October 24, 2024	430	\$19.47	\$0.00
October 24, 2024	434	\$60.83	\$0.00
October 24, 2024	450	\$420.69	\$0.00
October 24, 2024	710	\$834.33	\$0.00
October 24, 2024	730	\$67.16	\$0.00
October 24, 2024	771	\$10.95	\$0.00
Total		\$23,951.47	\$0.00

Requester's Position

“Per attached proof of timely filing, the bill was submitted on 12.30.2024 .This document serves as an official request for reconsideration regarding the denial of the workers' compensation claim for the medical services provided to the attached patient. Per the EOB, the claim was denied due to ‘untimely filing.’ We respectfully request that you reconsider this denial.”

Amount in Dispute: \$23,951.47

Respondent's Position

“The Carrier received a bill from the Requester for DOS 10/24/2024 on 6/03/2025. The billing was denied for timely filing. There was no reference made on the billing package that the bill was anything more than a new bill. Additionally, per rule 133.210, facility bills require the submission of an itemized statement . Reference is made on the EOR to that missing documentation as well as the reference to the rule allowing the denial of bills for not being timely filed.”

Response Submitted by: CorVel Healthcare Corporation

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.
3. [The Texas Labor Code \(TLC\) §408.027](#) sets out the rules for timely submission of claims by health care providers.
4. [TLC §408.0272](#) sets out the exceptions to the timely filing of a medical bill.

Denial Reasons

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

- 29 – Time limit for filing claim/bill has expired.
- RM2 – Time limit for filing claim has expired.
- Note: Effective 9/1/05, providers have 95 days to submit bills to the insurance carrier for reimbursement. Your bill exceeds this limit. Reimbursement is denied in accordance with Section 408.027 of the Act.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Is the requester entitled to reimbursement for the services in dispute?

Findings

1. The requester is a health care provider that rendered disputed services in the state of Tennessee to an injured employee with an existing Texas Worker's Compensation claim. The DWC finds the following:
 - The healthcare provider was dissatisfied with the insurance carrier's final action.
 - The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration.
 - The health care provider has requested medical fee dispute resolution under 28 TAC §133.307.

Because the requester has sought the administrative remedy under 28 TAC §133.307 for resolution of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The requester is seeking reimbursement in the amount of \$23,951.47, for emergency hospital services, rendered on October 24, 2024.

With a few exceptions, 28 TAC §133.20 (b) and Texas Labor Code (TLC) Sec. §408.027(a) requires the submission of medical bills not later than 95 days from the date of service. TLC §408.0272 (b) provided the exceptions to this requirement, which include:

- The health care provider filed the bill to
 - an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured
 - a health maintenance organization that issues evidence of coverage under which the injured employee is a covered enrollee; or
 - a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
- the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

TLC §408.0272 (d) also states that the period for submitting a claim for payment may be extended by the agreement of the parties.

The DWC finds there is insufficient evidence that the requester submitted a complete medical bill to the insurance carrier within 95 days after the date the services were provided. There was insufficient that the bill in question qualified for any of the allowed exceptions, nor was there any evidence that an agreement had been reached with the insurance carrier to extend the time limit for filing the medical bills.

The findings established that the requester did not submit sufficient evidence to support that the medical bills were submitted within 95 days after the dates of service. Therefore, the DWC concludes that the requester is not entitled to reimbursement for the services in question.

Conclusion

The outcome of this medical fee dispute is determined by the evidence presented by both the requester and the respondent during the adjudication process. While it is acknowledged that not all evidence may have been discussed in detail, all information submitted was duly considered in reaching a resolution.

DWC finds the requester has not established that reimbursement is due.

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

August 20, 2025

Date

Your Right to Appeal

Either party to this medical fee dispute has the right to seek review of this decision under 28 TAC §133.307, which pertains to disputes filed on or after June 1, 2012.

A party wishing to seek 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 adhere to the instructions provided on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. You must submit your request to DWC within 20 days from the date you receive this decision. You can send your request via fax, mail, or by delivering it in person to DWC, using the contact details provided on the form or those of the field office managing your claim. It is imperative that your request is made within the specified timeframe to ensure proper handling of your case. Should you have any questions regarding DWC Form-045M, please contact CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

When seeking a review of the Medical Fee Dispute Resolution (MFDR) decision, the party initiating the review shall deliver a copy of the request to all other parties involved in the dispute simultaneously with the filing of the request with the Department of Workers' Compensation (DWC). Additionally, it is essential to include a copy of the Medical Fee Dispute Resolution Findings and Decision, along with any other required information as specified 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 tres o correo electrónico CompConnection@tdi.texas.gov.