



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Methodist Richardson Medical

**Respondent Name**

Great American Alliance Insurance

**MFDR Tracking Number**

M4-25-3125-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

July 28, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 20, 2024	Emergency Room Visit	\$999.39	\$0.00

### Requester's Position

"Requesting review of compensability."

**Amount in Dispute:** \$999.39

### Respondent's Position

"The MFDR request filed with TDI documents the Carrier and Respondent as being Great American Alliance, which is not [redacted] workers' compensation carrier. [redacted] is self-insured. In addition, the actual work injury of [redacted] with [redacted], which Claims Administrative Services administered as the TPA, was for a [redacted] due to a fall. The current request is for treatment of a [redacted] which appears to have occurred on [redacted]. There has been no medical provided which would relate the [redacted]. The employer, [redacted] has never been notified by the claimant of a work-related [redacted]. It is our position that the [redacted] injury of [redacted] did not happen at [redacted] and we maintain the denial. It is a possibility the MFDR should be sent to Great American Alliance as documented on the MR100 filed. Should there be any questions, please let us know.

**Response Submitted by:** Claims Administrative Services, Inc. (CAS)

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Sec. §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [Rule §133.305](#) Medical Dispute Resolution – General
2. [Rule §133.307](#) Medical Fee Dispute Resolution
3. [Rule §133.250](#) Reconsideration for Payment of Medical Bills
4. [Sec. 408.0272](#) Certain Exceptions for Untimely Submission of Claim
5. [Rule §133.20](#) Medical Bill Submission by Health Care Provider
6. [Rule §141.1](#) Requesting and Setting a Benefit Review Conference

### Denial Reasons

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

- 177 – Claim denied because this is not a work-related injury/illness and thus not the liability of the workers compensation carrier.
- P2 – Not a work-related injury/illness and thus not the liability of the workers compensation carrier.
- Note: We have no record of an [redacted] as related to a work injury.

### Issues

1. Was the medical bill submitted to the correct insurance carrier in accordance with 28 TAC §133.20?
2. Did the requester submit documentation proving the bill was submitted to the correct workers' compensation insurance carrier before filing for medical fee dispute resolution (MFDR)?

### Findings

1. The requester is seeking reimbursement of \$999.39 for emergency room services provided on August 20, 2024.

The insurance carrier (Claims Administrative Services, Inc., on behalf of Plano ISD) denied the claim, asserting the injury was not work-related and thus not their liability.

CAS suggests the correct carrier might be Great American Alliance, based on the MR100 form. The requester did not provide evidence that the bill was submitted to the correct insurance carrier.

Per 28 TAC §133.307, the requester failed to include required documentation, such as:

- Paper copy of the bill submitted in accordance with §133.20
- Paper copy of the appeal per §133.250
- Copy of all related EOBs or convincing documentation of carrier receipt if no EOB was received

The Division of Workers' Compensation (DWC) finds the requester did not meet its burden of proof, to satisfy that the services in dispute were billed and audited by the carrier on record with the DWC.

2. According to Texas Labor Code §408.0272(c):

A provider who erroneously submits a claim to the wrong entity forfeits the right to reimbursement unless the claim is submitted to the correct carrier within 95 days after being notified of the error.

- CAS notified the requester of the denial and disputed liability.
- The requester failed to show documentation that they corrected the submission within the 95-day period.

The requester did not comply with the requirements of 28 TAC §§133.20 and 133.307, nor did they submit documentation proving timely resubmission to the correct carrier as required by Texas Labor Code §408.0272(c). Therefore, reimbursement is not recommended.

Conclusion

The resolution of this medical fee dispute is determined by the evidence provided by both the requester and the respondent during the adjudication process. While not all evidence may have been thoroughly discussed, all relevant information was considered in reaching a decision.

The 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

\_\_\_\_\_  
September 26, 2025  
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](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252- 7031, Option three, 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 DWC. **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 512-804-4812.