



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

CASTLE HILLS ASC LP

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-25-3130-01

Carrier's Austin Representative

Box Number 19

Date Received

July 30, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2019	Codes 29827, 20926 and 64418	\$18,610.00	\$0.00

Requester's Position

"Please reprocess bill for DOS: 12/05/2019 in the billed amount of \$18610.00, for payment, as we would like to dispute. Our records indicate payment was denied due to claim missing healthcare provider license and not being filed in a timely manner."

Amount in Dispute: \$18,610.00

Respondent's Position

"Under Division Rule 133.307(c)(1)(A), a Request for Medical Fee Dispute Resolution must be provided within one year of the date of service. It does not appear that Methodist Health System's request for medical fee dispute resolution was made until June 24, 2025. Accordingly, the dates of service at issue is outside of the one-year deadline and the Division lacks jurisdiction to consider this dispute."

Response Submitted by: ESIS

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 the payment for the disputed services with the following claim adjustment codes:

- 1 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 2, 3 – Bill is denied; invalid/ missing healthcare provider license number. Please re-submit with appropriate license number for review

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 ambulatory surgical center services provided on December 5, 2019, and billed under CPT codes 29827, 20926, and 64418. Pursuant to 28 Texas Administrative Code (TAC) §133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be filed no later than one year from the date of the disputed service, except under certain limited exceptions specified in subsection (B) of the same rule.

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, Codes 29827, 20926 and 64418 were provided on December 5, 2019. The Division received the MFDR request on July 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).

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 services in dispute.

Authorized Signature

	August 22, 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. 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.

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.