

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Methodist Health Systems

Respondent Name

Indemnity Insurance Co of North America

MFDR Tracking Number

M4-25-3367-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

June 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 4 – 6, 2024	Inpatient procedure	\$24,057.38	\$0.00

Requester's Position

"Requesting review of underpaid bill.

Amount in Dispute: \$24,057.38

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs Stanford. The representative was notified of this medical fee dispute on August 22, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

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

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

Neither party submitted an explanation of benefits related to the disputed service.

Issues

1. Did the requester waive the right to medical fee dispute resolution?

Findings

1. The requester is seeking payment for inpatient hospital services rendered from June 4 – 6, 2024. DWC Rule 28 TAC §133.307(c)(1) states:
"Timeliness. A requester shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.
(A) A request for medical fee dispute resolution 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.
(B) A request may be filed later than one year after the date(s) of service if:
(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requester receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requester received the final decision on medical necessity, inclusive of all appeals, related to health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or
(iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The dates of the service in dispute were June 4 – 6, 2024. The request for medical dispute resolution was received at the Division on June 9, 2025.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requester has waived their right to MFDR for dates of service in dispute.

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.

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

October 17, 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. 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 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 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 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.