



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

David West, D.O.

Respondent Name

Starr Indemnity & Liability Company

MFDR Tracking Number

M4-25-3425-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

August 27, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 15, 2024	Designated Doctor/Missed Appointment 99456-52	\$100.00	\$0.00

Requester's Position

"Reconsideration sent with proof of timely filing and it was denied."

Amount in Dispute: \$100.00

Respondent's Position

"This dispute involves a date of service of 11/15/24 with an amount originally billed at \$100.00. The amount in dispute is \$100.00. The carrier's position remains consistent with its EOB. A request for reconsideration was made on 8/29/2025 and no additional allowance was made. The carrier's position remains consistent with its EOB."

Response Submitted by: Flahive, Ogden & Latson

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 – The time limit for filing claim/bill has expired.
- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.
- OA – Other adjustment.

Issues

1. Is the requester entitled to reimbursement for the service in dispute?

Findings

1. The requester is seeking reimbursement in the amount of \$100.00, for a missed designated doctor appointment that was scheduled for November 15, 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 was insufficient evidence that the requester submitted the medical bill to the insurance carrier within 95 days after the date the services were provided. There was insufficient evidence that the bill in question qualified for any of the exceptions allowed, 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

September 24, 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.