TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
METHODIST HEALTH SYSTEMS

Respondent Name
CITY OF ARLINGTON

MFDR Tracking Number
M4-25-3435-01

Carrier's Austin Representative
Box Number 19

Date Received
August 28, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 17, 2024	Emergency room visit	$521.14	$0.00

Requester's Position

"Requesting review of timely filing. I have attached our notes showing that the adjuster called to provide work comp information on 11/27/24, after the timely filing deadline. Prior to this call, we were not aware of a worker's compensation claim."

Amount in Dispute: $521.14

Respondent's Position

"Date of service 05/17/2024 is past timely filing for MDR per Division Rule 133.3079c[sic]. (Request for medical fee dispute resolution must be filed' no later than one year after the date(s) of service in dispute.') MDR received date 8/29/2025. Therefore, the Division does not have jurisdiction over the dispute, and it must dismiss the request for resolution for dates of service 05/17/2024."

Response Submitted by: Injury Management Organization Inc

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:

- 29 – the time limit for filing has expired
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – TDI Level 1 appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, subchapter U of this title
- Payment disallowed: This item is an STV – packaged code that is packaged into the payment for code with status indicator S, T or V; or a conditional packaging code, for which payment is packaged into a single payment for specific combinations of services

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 emergency room services provided on May 17, 2024. According to 28 Texas Administrative Code (TAC) §133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the same provision.

   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, emergency room services were provided on May 17, 2024. The Division received the MFDR request on August 28, 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 disputed services.

Authorized Signature

[redacted] September 12, 2025

Signature Medical Fee Dispute Resolution Officer 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. 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 electronico CompConnection@tdi.texas.gov.