TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Resolute Health System

Respondent Name
Ace American

MFDR Tracking Number
M4-26-0061-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
September 2, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 30 – May 1, 2024	0250	$977.00	$0.00
	0278	$25206.50	$0.00
	0300	$3015.00	$0.00
	0320	$851.00	$0.00
	0360	$32018.25	$0.00
	0370	$8900.00	$0.00
	0424	$657.00	$0.00
	0430	$578.00	$0.00
	0434	$657.00	$0.00
	0636	$7002.00	$0.00
	0710	$7485.00	$0.00
	0762	$7299.00	$0.00
	WC ADJUSTMENT(S)	-85229.40	$0.00
	Total	$9,416.55	$0.00

Requester's Position

"The Hospital billed CORVELL-CORCARE, but the bill was denied not paid/reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent, CORVELL-CORCARE has not rendered proper payment."

Amount in Dispute: $9,416.55

Respondent's Position

"A request for reconsideration was received the carrier 08/04/2025… The accompanying "letter" from the HCP indicated "the bill was underpaid." The HCP failed to provide any supporting documentation showing why they believe payment made by Corvel represented an underpayment. Corvel maintained the original payment. …pursuant to Division rule §133.307(c) and (c)(1)(A) a request for MFDR 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. …Corvel asserts the requestor is entitled to $0.00 reimbursement for outpatient services in dispute based on the requestor's failure to request medical fee dispute resolution no later than one year after the DOS in dispute."

Response submitted by: Corvel

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

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

- 107 – Denied – qualifying svc not paid or identified.
- 234 – This procedure is not paid separately.
- 97/P14– Charge included in another charge or service.
- RM7 – Invalid code for CMS payment-resubmit w/valid code.
- RZ0 - Status Indicator: Q4 packaged lab service.
- W3 – Appeal/reconsideration.
- 16 – Svc lacks info needed or has billing error(s).
- 45 – Contract/legislated fee arrangement exceeded.
- RN – Not paid under OPPS: services included in APC rate.

Issues

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

Findings

1. The requester is seeking additional payment for outpatient hospital services rendered from April 30, 2024 through May 1, 2024. The payment was reduced based on reduction codes listed above. 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 the 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 are April 30, 2024 through May 1, 2025. The request for medical dispute resolution was received at the Division on September 2, 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	September 30, 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.