

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

RESOLUTE HEALTH
SYSTEM

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-26-0177-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

September 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2024	Outpatient Hospital Charges	\$8,242.00	\$0.00

Requester's Position

"The Hospital billed TEXAS MUTUAL, but the bill was denied not paid/reimbursed appropriately."

Amount in Dispute: \$8,242.00

Respondent's Position

"One year from disputed date 03/22/2024. The TDI/DWC date stamp lists the received date as 09/18/2025 on the requestor's DWC-60 packet, a date greater than one year. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual

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

- CAC-P12 – Workers Compensation jurisdictional fee schedule adjustment
- CAC-16 – Claim service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
- 714 – Accurate license, CPT /HCPCS, NDC # dates, units, days supply, modifiers are required. Submit corrections w/l 95 days from DOS
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT code descriptions/instructions

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 Outpatient Hospital Charges provided on March 22, 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, Outpatient Hospital Charges were provided on March 22, 2024. The Division received the MFDR request on September 18, 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, DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

[Redacted Signature]

Signature

[Redacted Signature]

Medical Fee Dispute Resolution Officer

October 3, 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, 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.