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
Providence East

Respondent Name
East Texas Education Insurance

MFDR Tracking Number
M4-26-0208-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
September 22, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 25 – 2024 through February 7, 2024	0111	$54568.85	$0.00
January 25 – 2024 through February 7, 2024	0250	$44076.28	$0.00
January 25 – 2024 through February 7, 2024	0255	$2296.39	$0.00
January 25 – 2024 through February 7, 2024	0278	$191497.73	$0.00
January 25 – 2024 through February 7, 2024	0300	$12689.45	$0.00
January 25 – 2024 through February 7, 2024	0320	$11835.00	$0.00
January 25 – 2024 through February 7, 2024	0350	$33572.22	$0.00
January 25 – 2024 through February 7, 2024	0360	$120210.12	$0.00
January 25 – 2024 through February 7, 2024	0370	$17283.18	$0.00
January 25 – 2024 through February 7, 2024	0420	$5197.49	$0.00
January 25 – 2024 through February 7, 2024	0424	$665.97	$0.00
January 25 – 2024 through February 7, 2024	0430	$4087.10	$0.00
January 25 – 2024	0450	$7215.44	$0.00

through February 7, 2024			
January 25 – 2024 through February 7, 2024	0710	$11373.81	$0.00
January 25 – 2024 through February 7, 2024	WC ADJUSTMENTS	$-511918.98	$0.00
	Total	$6370.05	$0.00

Requester's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed CLAIMS ADMINISTRATORS, but the bill was denied not paid/reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent, CLAIMS ADMINISTRATORS has not rendered proper payment."

Amount in Dispute: $6370.05

Respondent's Position

"The bill was initially processed and paid on 4/12/2024. Reimbursement was based on the all-inclusive method of the DRG based Inpatient Hospital Fee Guideline. A payment of $23,340.09 was issued. …On 7/22/2024 a reconsideration was processed. At that time, the hospital now requesting separate reimbursement of the implant invoices. However, we did not receive legible copies of the Implant Invoices that included the certifying sentence required in Rule §134.404. As such, the reconsideration was denied additional allowance and an EOR comment added explaining that decision. …It is our position correct payment has been made, and no additional reimbursement is due."

Response submitted by: Claims Administrative Services, Inc.

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 305 – The implant is included in this billing and is reimbursed at the higher percentage calculation.
- 468 – Pricing is based on the Medicare Hospital Inpatient Prospective Payment System methodology.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 375 – Please see special *note* below.
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- It appears your facility is now requesting separate implant reimbursement. For consideration we will require a legible implant invoice which matched the implants billed along with the required "By Penalty of Law" confirmation."

Issues

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

Findings

1. The requester is seeking additional reimbursement for inpatient hospital services rendered from January 25, 2024 through February 7, 2024. The respondent paid the charges based on Medicare's IPPS payment methodology without separate payment of implants.

   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 are in January and February of 2024. The request for medical dispute resolution was received at the Division on September 22, 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 14, 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.