



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Legent Interventional Pain Center

**Respondent Name**

TPCIGA for Arrowood Indemnity

**MFDR Tracking Number**

M4-26-0377-01

**Carrier's Austin Representative**

Box Number 50

**DWC Date Received**

October 6, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2024	63685, C1820	\$4,064.82	\$0.00

### Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of their reconsideration dated July 30, 2025 that states, "We have been underpaid per the Texas work compensation fee schedule..."

**Amount in Dispute:** \$4,064.82

### Respondent's Position

"TPCIGA supports the position statement provided by our medical review vendor Ethos Risk Services..."

**Response submitted by:** Texas Property & Casualty Insurance Guaranty Association

## 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:

- 29 – The time limit for filing has expired.
- 4271 – Per TX Labor Code Sec. 408.207, providers must submit bills to payors within 95 days of the date of service.
- W3 – Reconsideration
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1241 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
- 6000 – Request for reconsideration
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 4123 – Allowance is based on Texas ASC device intensive procedure calculation and guidelines.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indicator determines the service is package or excluded from payment.

### Issues

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

## Findings

1. The requester is seeking additional payment for surgical procedure rendered in an ASC on July 19, 2024. The insurance carrier made a payment of \$26,147.99 and upheld the payment reduction on reconsideration and in their response to MFDR. 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 July 19, 2024. The request for medical dispute resolution was received at the Division on October 6, 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

_____	_____	October 24, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).