

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Concho County Hospital

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-26-0600-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

October 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 12, 2023	Emergency Hospital Visit	\$13,569.91	\$0.00

Requester's Position

"Despite [redacted] timely submission of her claim to Concho County Hospital, the associated medical bills remain unpaid nearly two years later. Upon inquiry, Corvel, the insurance provider responsible, informed us that the delay stemmed from duplicate billing by Concho County Hospital. At Corvel's direction, the hospital resubmitted the corrected bill; however, payment has still not been issued. In subsequent communications, Corvel advised that a Medical Fee Dispute Resolution Request must now be submitted to resolve the matter."

Amount in Dispute: \$13,569.91

Respondent's Position

"Finally, the date in which to file a MFDR timely has passed. The Requestor had one year from date of service (12/12/2023) to file a Medical Fee Dispute Resolution with the division. The Division received the request to file the MFDR on 10/21/2025."

Response Submitted by: CorVel Healthcare Corporation

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:

- 18 - Duplicate Claim/Service
- JZ - No drug amounts were discarded during an encounter
- XU – Unusual Non-Overlapping Service.
- TC - Technical Component
- 25 - Separate E&M Service, Same Physician
- R1 - Duplicate Billing
- 16 - Svc lacks info needed or has billing error(s)
- 252 - Attachment required to adjudicate claim/service
- P12 - Workers' Compensation State Fee Schedule Adj
- 234 – This procedure is not paid separately.
- 29 – Time limit for filing claim/bill has expired.
- P14 – Payment is included in another svc/procdre occurring on same day.
- RM2 – Time limit for filing claim has expired.
- RZ0 – Status indicator: Q4 Packaged Lab service.
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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 an emergency hospital visit provided on September 12, 2023. 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 on the basis of 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, an emergency hospital visit was provided on September 12, 2023. The Division received the MFDR request on October 21, 2025, which is more than one year after the date 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).

Therefore, 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.

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.

The Division finds the requester has not established that reimbursement is due.

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

		November 10, 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 electrónico CompConnection@tdi.texas.gov.