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
Doctors Hospital at Renaissance

Respondent Name
Hartford Insurance Co of Illinois

MFDR Tracking Number
M4-26-0749-01

Carrier's Austin Representative
Box Number 47

DWC Date Received
November 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 4, 2024	C1776	$21,289.40	$0.00
October 4, 2024	73020	$105.51	0.00
October 4, 2024	96374	$248.88	0.00
October 4, 2024	All others	$0.00	$0.00
	Total	$10,479.16 [sic]	$0.00

Requester's Position

"According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $10,479.16

Respondent's Position

"Bill paid per fee schedule and the OPPS schedule allowance with a partial denial as included and or bundled."

Response submitted by: The Hartford

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) §133.305 sets out the procedures for resolving medical disputes.
2. 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:

- 7 – The cost of the supply is included in the value of another procedure performed on the same date of service.
- 96 – Non-covered charges.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- W3 – Bill is a reconsideration or appeal.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 797 – Service not paid under Medicare OPPS.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 906 – In accordance with clinical based coding edits (National Correct Coding Initiatives/Outpatient Code Editor), component code of comprehensive medicine evaluation and management services procedure (9000-99999) has been disallowed.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 2008 – Additional payment made on appeal/reconsideration.
- 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.
- P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

- 269 – This billing is for a service unrelated to the work illness or injury.

Issues

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

Findings

1. The requester is seeking payment for outpatient hospital services rendered in October of 2024. 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 October 4, 2024. The request for medical dispute resolution was received at the Division on November 17, 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 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 18, 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.