



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Sun City Orthopaedics & Hand Surgery Specialists

**Respondent Name**

University of Texas System

**MFDR Tracking Number**

M4-26-0867-01

**Carrier's Austin Representative**

Box Number 46

**DWC Date Received**

June 18, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 3, 2022	99456	\$850.00	\$0.00

### Requester's Position

"I'm writing this letter of dispute due to our bill being denied due to the procedure code being inconsistent with the modifier used or a required modifier missing. The bill has always been billed with modifier WP due to the patient meeting his MMI. I have attached a copy of the medical note and the impairment rating report. Please reconsider payment for this bill in the amount of \$850.00."

**Amount in Dispute:** \$850.00

### Respondent's Position

"Date of service 11/3/2022 is past the timely filing for MDR per Division Rule 133.3079c. (Request for medical fee dispute resolution must be filed "no later than one year after the date(s) of service in dispute.") MDR received date submitted to TPA 11/26/2025. Therefore, The Division does not have jurisdiction over the dispute, and it must dismiss the request for resolution for dates of service 11/03/2022."

**Response Submitted by:** Injury Management Organization Inc

## 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:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

### 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 a designated doctor exam provided on November 3, 2022. 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, designated doctor exam was provided on November 3, 2022. The Division received the MFDR request on November 24, 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**

_____	_____	December 8, 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). 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](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 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](mailto:CompConnection@tdi.texas.gov).