



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Methodist Richardson Medical Center

**Respondent Name**

Acadia Insurance Co

**MFDR Tracking Number**

M4-26-1143-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

December 16, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 28, 2025	Emergency Visit	\$58,532.57	\$0.00

### Requester's Position

"Requesting overturn of timely filing denial. Proof of submission to the incorrect payer within the timely filing period is attached."

**Amount in Dispute:** \$58,532.57

### Respondent's Position

"The provider has not provided sufficient proof to support its position that its submission of the medical bill to the correct carrier was timely. Accordingly, the provider is not entitled to any reimbursement."

**Response Submitted by:** Flahive, Ogden & Latson

## 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.
2. [28 TAC §133.20](#) sets out requirements of medical bill submission.
3. [28 TAC §102.4](#) details the general rules for Non-Division Communication.
4. [Texas Labor Code 408.0272](#) sets out the workers compensation timely billing and exceptions guidelines.

### Denial Reasons

The insurance carrier denied the disputed services with the following claim adjustment codes.

- 29 – The time limit for filing has expired.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97 – Workers compensation jurisdictional fee schedule adjustment.
- M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
- 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, Chapter U of this title.

### Issues

1. Did the requester support timely submission of medical claim?

### Findings

1. The requester is seeking reimbursement of outpatient hospital services rendered in April 2025. The insurance carrier denied the services stating the medical bill was not submitted within 95 days of the date of service.

DWC Rule 28 TAC §102.4 (h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:

- (1) the date received if sent by fax, personal delivery, or electronic transmission; or
- (2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

DWC Rule 28 TAC §133.20 (b) states in pertinent part,

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Texas Labor Code 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to submit a timely claim for payment to the insurance carrier under Section 408.0272(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

- (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
  - (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
  - (B) a health maintenance organization that issues evidence of coverage under which the injured employee is a covered enrollee; or
  - (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title;
- (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

Review of the submitted documentation found the requester submitted a screen shot from records from users at enablecomp.com. These records are insufficient to support what insurance carrier a claim was submitted to or the dates of services of the submitted claim.

The greater weight of evidence supports the correct workers' compensation carrier (Acadia Insurance Company) received the bill, on August 29, 2025. This date is greater than 95 days from the date of service.

Additionally, DWC finds there is insufficient information to support any of the exceptions described above. No payment is recommended.

## 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 Methodist Richardson Medical Center has not established that reimbursement of \$58,532.57 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**

_____	_____	January 8, 2026
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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).