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

University Physicians Inc

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-1305-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

January 9, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
February 19, 2025	99204	$530.00	$0.00
February 19, 2025	73140	$28.00	$0.00
February 28, 2025	01810	$2800.00	$0.00
February 28, 2025	26350, 64831	$7383.00	$0.00
	Total	$10,741.00	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a copy of a document titled, "Provider Request for Reconsideration" that states, "This claim was initially sent to your member's commercial insurance, as no workers compensation insurance information was provided at the time of service. Your member did not notify us of this coverage until 6/30/25. Once we were notified our records were updated and claim was submitted electronically on 7/2/2025."

Amount In Dispute: $10,741.00

Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by UNIVERSITY PHYSICIANS INC. and has determined the DWC-60 has been submitted prior to the final decision on a pending appeal request. …At this time, Texas Mutual maintains its position until the request for reconsideration has been finalized. Our position is that no payment is due."

Response Submitted By: Texas Mutual Insurance

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code Section 413.031 and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.203 sets out the fee guidelines for professional medical services.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 926 – Request for reimbursement was previously submitted by another entity. Refer to Rule 140.8(I).
- CAC-P12 – Worders' compensation jurisdictional fee schedule adjustment.
- G14 – Pricing is calculated based on the medical professional fee schedule facility site of service value.
- CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- J08 – Pricing has been calculated according to the guidelines for non-physician providers.
- R43 – Services rendered outside of the claim jurisdiction are priced according to fees and limits est b governing fee sched for the claim.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

- 420 – Supplemental payment.
- CAC-59 – Processed based on multiple or concurrent procedure rules. (For example, multiple surgery or diagnostic imaging, concurrent anesthesia.)
- J10 – Pricing has been calculated according to the multiple surgical procedure reduction value.
- J16 – This procedure code was ranked as the primary service when considered for multiple procedure reduction, as a result no reduction was taken.
- G23 – Pricing has been calculated according to the anesthesia fee schedule guidelines.

Issues

1. What is DWC considering in this medical fee dispute?
2. Were the services in dispute rendered outside the state of Texas?
3. Did the requester meet the requirements of applicable rule when submitting the MFDR request?

Findings

1. The requester is seeking reimbursement of professional medical services rendered in February 2025 in the State of Colorado. The amount in dispute is $10,741.00. The insurance carrier (Texas Mutual) supports payment were made on January 27, 2026 in the amount of $4,287.14 via check 004313797 and $14.40 via check 004311892 on January 23, 2026.
2. The requestor is a health care provider that rendered disputed services in the state of Colorado to an injured employee with an existing Texas Workers' Compensation claim.

   The health care provider was dissatisfied with the insurance carrier's final action. The health care provider has requested medical fee dispute resolution under 28 TAC Section 133.307.

   Because the requestor has sought the administrative remedy outlined in 28 TAC Section 133.307, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
3. The rule that defines what information must be included with a request for MFDR is found in 28 TAC 133.307(2)(J) and states in pertinent parts a copy of all medical bills related to the dispute, as described in §133.10 of this chapter… as original submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter.

   The submitted documents did not include medical bill(s) for date of service February 28, 2025 for codes 01810, 26350 and 64831.

As the required elements of the request for MFDR was not met, no additional payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence the requester and the respondent presented 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 Sections 413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 29, 2026 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.