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

Providence Memorial Hospital

MFDR Tracking Number

M4-26-2156-01

DWC Date Received

April 1, 2026

Respondent Name

Alaska Insurance Co.

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 24, 2025	73562-RT	$0.00	$0.00
April 24, 2025	96372	$0.00	$0.00
April 24, 2025	99284-25	$791.68	$0.00
April 24, 2025	J2270	$0.00	$0.00
	Total	$791.68	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. However, they did submit a document tilted, “Reconsideration” dated November 2, 2025 which states, “…the patient did not provide their claim information at the time of service. The patient called on 08/04/2025 with their claim information and the bill was sent on 08/12/25. The bill was submitted within the required timeframe of 95 days.”

Amount In Dispute: $791.68

Respondent's Position

"The Respondent has reviewed the bill received from the HCP for DOS 04/05/2025 [sic]. The initial provider billing for this DOS was received 08/25/2025. …There was no indication on the original billing the reason for late submission. On 12/29/2025, the Carrier received a Request for Reconsideration from HCP. This billing also failed to support overriding the timely filing denial. As such, the timely filing denial was maintained."

Response Submitted By: CorVel

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 133.20 sets out the requirements for medical bill submission.
3. 28 TAC Section 102.4 details the general rules for non-division communication.
4. Labor Code Section 408.0272 sets out workers' compensation guidelines for timely billing and exceptions.

Adjustment Reasons

- 29 – The time limit for filing claim/bill has expired.
- P14 – Payment is included in another svc/procdr occurring on same day.
- RN – Not paid under OPPS; services included in APC rate.
- TC – Technical Component.

Issues

1. What is DWC considering in this medical fee dispute?
2. Did the requester support timely submission of the medical bill?

Findings

1. The requester is seeking reimbursement of outpatient emergency room services rendered on April 24, 2025 in the amount of $791.68.

2. 28 TAC Section 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.

28 TAC Section 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 Section 408.0272. (b) states in pertinent part,

(b) Notwithstanding Section 408.0272, a health care provider who fails to timely submit a 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.

3. 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 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	April 24, 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.