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

North Central Baptist Medical Center

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-2214-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

April 6, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
December 27, 2024	Hospital Outpatient	$12,616.76	$0.00
	Total	$12,616.76	$0.00

Requester's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medical necessary services on the above dates of service. The Hospital billed TEXAS MUTUAL INSURANCE COMPANY ('TEXAS MUTUAL'), but the bill was denied, not paid and not reimbursed appropriately. However, despite the Hospital's efforts and Request for Reconsiderations sent, TEXAS MUTUAL has not rendered proper payment."

Amount In Dispute: $12,616.76

Respondent's Position

"The disputed date of service 12/27/2024 to 12/27/2024 is greater than one year from the TDI/DWC date-stamp of April 6, 2026, listed on the requestor DWC60 packet and has waived its right to DWC MDR."

Response Submitted By: Texas Mutual

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 133.305 sets out the procedures for resolving medical disputes.

Adjustment Reasons

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

1. UB-04 and itemized do not match. Please submit a complete/corrected bill
2. CAC-P12 – Workers' Compensation Jurisdictional fee schedule adjustment
3. 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
4. CAC-16 – Exact duplicate claim/service
5. CAC-193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
6. CAC-29 – The time limit for filing has expired
7. 715 – Service previously billed with different/incorrect codes, provider, claim etc. processed as correction only-no addtnl payment
8. 731 – Per 133.20 (B) provider shall not submit a medical bill later than the 95th day after the date the service
9. 877 – Bill previously processed. Refer to Rule 133.250 regarding request for reconsideration and submit with original EOB and corrected bill
10. CAC-18 – Exact duplicate claim/service
11. CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is DWC considering in this medical fee dispute?

2. Was this request for medical fee dispute resolution submitted timely?

Findings

1. The requester submitted a medical fee dispute seeking reimbursement in the amount of $12,616.76 for date of service December 27, 2024. The insurance carrier denied the services with denial reasons listed above and issued no payment.

2. A review of the submitted documentation finds that the services in dispute were rendered on December 2, 2024. According to 28 Texas Administrative Code (TAC) Section 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 Section 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 based on 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, Hospital outpatient services were provided on December 27, 2024. The Division received the MFDR request on April 6, 2026, which is more than one year after the date(s) 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 Section 133.307(c)(1)(B).

   The Division finds the requester has not established that reimbursement is due.

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 21, 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.