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

Doctors Hospital at Renaissance

Respondent Name

AIU Insurance Co

MFDR Tracking Number

M4-26-2614-01

Insurance Carrier's Austin Representative

BOX 19 Flahive Ogden & Latson

DWC Date Received

May 18, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 1, 2025	14041	$3,066.49	$0.00
May 1, 2025	26440F9	$2,657.35	$0.00
May 1, 2025	26440F7	$2,657.35	$0.00
May 1, 2025	26440F2	$2,657.35	$0.00
May 1, 2025	All others	$0.00	$0.00
	Total	$6,323.09	$0.00

Requester's Position

The requester did not submit a position statement with this request for MFDR. They did submit a document titled, "Request for Reconsideration" dated February 17, 2026 that states, "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount In Dispute: $6,323.09

Respondent's Position

"The carrier's position is that the provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

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.

Adjustment Reasons

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

- 197 – Precertification/authorization/notification/pre-treatment absent.
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.
- TX360 – Allowance for this procedure was made at the usual and customary amount for this geographical area.
- TX370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
- TX617 – This item or service is not covered or payable under the Medicare Outpatient fee schedule.
- TX618 – The value of this procedure is packaged into the payment of other services performed on the same date of service.
- TX975 – This line item was reviewed using the fair health charge benchmark databased module based on the provider geographic area.

- XXJ49 – The allowance for this line has been summed with other allowances on the bill and re-distributed evenly.

- XXU00 – Ther was no UR procedure/treatment request received.

Issues

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

2. Has the waived the right to MFDR for the services in dispute?

Findings

1. The requester is seeking reimbursement of outpatient hospital charges in the amount of $6,323.09. The submitted medical bill indicates dates of service from April 29, 2025 through May 1, 2025. Only the codes 14041, 26440F9, 26440F7, 26440F2 have amounts in dispute. All other lines submitted on the DWC060 have zero amount in dispute. DWC will review the submitted document to determine if this request was submitted timely.

2. The rule that pertains to the timely submission of request for Medical Fee Dispute Resolution is 28 TAC Section 133.307(c)(1) which states:

   "Timeliness. A requester shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.

   (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   (B) A request may be filed later than one year after the date(s) of service if:

   (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requester receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

   (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requester received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

   (iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

   The dates of the service in dispute are April 29, 2025 through May 1, 2025. The request for medical dispute resolution was received at the Division on May 18, 2026.

Insufficient evidence was submitted in support that an exception to the time limit for submitting a request for MFDR. The requester has waived there right to MFDR for the disputed dates of service.

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	June 17, 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.