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

Christus Mother Frances Hospital

Respondent Name

American Casualty Co of Reading PA

MFDR Tracking Number

M4-26-2776-01

Insurance Carrier's Austin Representative

BOX 57 Continental Casualty Co

DWC Date Received

June 4, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
November 20, 2024	Hospital Outpatient	$3,936.09	$0.00
	Total	$3,936.09	$0.00

Requester's Position

"This is a request for a Medical Fee Dispute Resolution on [injured employee] denied claim (ICN#) for Emergency services at CHRISTUS Health-Trinity Mother Frances (Jacksonville). The following is a summary of the denial from Workers Compensation, as well as clinical justification that supports a) the need for services as provided and/or b) documentation to support our accurately billed diagnose and procedures."

Amount In Dispute: $3,936.09

Respondent's Position

"Pursuant to Rule 133.307(c)(1)(A), a request for Medical 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) f service in dispute. 133.307(c)(1) The Division shall deem a request to be filed on the date the MDR section receives the request. Per the DWC 60, the date of receipt is June 4, 2026. As such, Dates of Service for 11/20/2024 is not to be considered by the Division as the request for MDR is untimely."

Response Submitted By: Law Office of Brian J Judis

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. 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
2. 56 – Significant, separately identifiable E/M service rendered
3. 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
4. 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed
5. 802 – Charge for this procedure exceeds the OPPS schedule allowance
6. P12 – Workers' Compensation Jurisdictional fee schedule adjustment
7. 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment or the payment status indictor determines the service is packaged or excluded from payment
8. 5211 – Nurse audit has resulted in adjusted reimbursement

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 dispute request seeking reimbursement in the amount of $3,936.09 for Outpatient Hospital services rendered on November 20, 2024. The insurance

carrier denied the services with the denial codes listed above (descriptions above) and issued no payment.

2. 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 November 20, 2024. The Division received the MFDR request on June 4, 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

[redacted] | [redacted] | June 25, 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 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.