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

Precision Sports Physical Therapy

Respondent Name

Texas Public School WC Project

MFDR Tracking Number

M4-26-2777-01

Insurance Carrier's Austin Representative

BOX 18 Creative Risk

DWC Date Received

June 4, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2025	97161	$230.00	$0.00
	Total	230.00	$0.00

Requester's Position

"Initially we sent the claim with diagnosis codes S83.92XA, R07.81, M25.562 and the claim was submitted to the payer on 05/08/2025 within the required timely filing limit. The claim was denied due to an invalid diagnosis code. Upon receiving the denial, we promptly corrected the diagnosis code and resubmitted the claim on 07/08/2025. However, the corrected submission was made within the allowable timeframe. We have attached supporting documentation, including the claim history, the initial denial EOB, and relevant medical records, as proof of timely filing. We respectfully request that you review the enclosed documentation, reconsider the claim, and process the payment accordingly."

Amount In Dispute: $230.00

Respondent's Position

"Respondent contends that Requestor did not timely submit its bill for payment within 95 days after the date it provided services in this claim in accordance with 133.20(b). Consequently, it is not

entitled to reimbursement in this claim … In reviewing Requestor's MFDR request, it is apparent that they, Precision Sports Physical Therapy, initially billed us, CRF, for a non-compensable condition and then attempted to correct their bill by submitting new bills to CRF with different diagnosis codes. However, because Requestor did not submit its corrected bills to CRF within 95 days from the date of service, CRF properly denied payment of those bills."

Response Submitted By: Creative Risk Funding

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. 29 – The time limit for filing has expired
2. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
3. P12 – Workers' compensation jurisdictional fee schedule adjustment
4. W3 – Reconsideration appeal
5. Notes: This bill was considered a new bill on 12.08.2025 due to original diagnosis codes changed/ added/ removed upon resubmission. Previous gross recommended payment amount on line: $0; Previous recommended payment amount on line: $0
6. Notes: This bill is considered a new bill due to original diagnosis codes changed/added/removed upon resubmission
7. Previous recommended history on DCN(s): 199520 = $0.00 (ANSI29)

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 request in the amount of $230.00 for service billed code 97161 rendered on May 7, 2025. The insurance carrier denied the service with denial reasons listed above (descriptions listed 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, code 97161 provided on May 7, 2025. 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. Click or tap here to enter text.

Authorized Signature

[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.