TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TEXAS HEALTH FORT WORTH

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE COMPANY

MFDR Tracking Number
M4-23-3138-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
August 11, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 5, 2022, and September 6, 2022	Inpatient Facility Charges	$8,807.86	$0.00
	Total	$8,807.86	$0.00

Requestor's Position

"The hospital appealed and requested reconsideration several times, but each time the denial decision was upheld due to lack of preauthorization. The hospital's claim should not have been denied for lack of preauthorization because preauthorization was not required since the patient was admitted inpatient directly from the ER. The hospital expects payment in the amount of $8,807.86 on this claim."

Amount in Dispute: $8,807.86

Respondent's Position

"The bill has been reviewed and denial stands as Pre-authorization was required, but not requested for this service per DWC Rule 134.600… This has been reviewed and it appears this does not meet the criteria for 'Medical emergency' based on the records provided…"

Response Submitted by: Liberty Mutual Fire Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.2 defines words and terms related to medical bill processing.
3. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent utilization review, and voluntary certification of health care.

Denial Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- 5917 – Pre-Authorization was required, but not requested for this service per rule 134.600.
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- X598 – Claim has been re-evaluated based on additional documentation submitted, no additional payment due.

Issues

1. Did the requestor submit documentation to support that the service in dispute was an emergency?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor, Texas Health Fort Worth, submitted medical fee dispute M4-23-3138-01 to DWC for resolution pursuant to 28 TAC §133.307. The dispute concerns an inpatient facility services provided by the requestor on September 5, 2022.

   The insurance carrier denied the facility charges with denial reason "5917 – Pre-Authorization was required, but not requested for this service per rule 134.600."

   The requestor submitted the dispute requesting reimbursement for the facility charges rendered on September 5, 2022. The disputed service is governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307.

28 TAC §133.2 (1)(5) (A)(i-ii), states, "(5) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part…"

The requestor has the burden to prove that the service in dispute was provided as emergency care. DWC concludes that the provider failed to meet its burden of proof to establish that the date of service in dispute was emergency care.

2. 28 TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care provided on the dates of service was emergency care and was not sufficient to show that the care provided was for a medical emergency as defined in 28TAC §133.2. Because the treatment for this date of service was not shown to be emergency care, the insurance carrier is not liable for reimbursement.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 14, 2024
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 §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 1-800-252-7031, option 3 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 the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.