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

Requestor Name
Providence Sierra

Respondent Name
Liberty Mutual Fire Insurance Co

MFDR Tracking Number
M4-24-1203-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
January 29, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 15 – 23, 2022	0111	$4,783.00	$0.00
December 15 – 23, 2022	0250	$27,199.00	$0.00
December 15 – 23, 2022	0300	$26,018.00	$0.00
December 15 – 23, 2022	0320	$3,062.00	$0.00
December 15 – 23, 2022	0350	$8,768.00	$0.00
December 15 – 23, 2022	0360	$61,953.00	$0.00
December 15 – 23, 2022	0370	$10,382.00	$0.00
December 15 – 23, 2022	0420	$1,033.00	$0.00
December 15 – 23, 2022	0424	$3,187.00	$0.00
December 15 – 23, 2022	0450	$6,536.00	$0.00
December 15 – 23, 2022	0483	$9,617.00	$0.00
December 15 – 23, 2022	0610	$6,229.00	$0.00
December 15 – 23, 2022	0710	$6,610.00	$0.00
December 15 – 23, 2022	0730	$854.00	$0.00
December 15 – 23, 2022	WC ADJUSTMENTS	$-168,552.91	$0.00
	Total	$41,155.17	$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Liberty Mutual, but the bill was underpaid. However, despite the Hospital's efforts and Request for Reconsideration, Liberty Mutual has not rendered proper payment."

Amount in Dispute: $41,155.17

Respondent's Position

"This bill for DOS 12/15/2022 to 12/23/2022 will not be reviewed as this dispute has been submitted past the timely filing deadline per Rule 133.307: A request for MFDR that does not involve issues identified is subparagraph (B)… shall be filed no later than one year after the date(s) of service in dispute. This MFDR was filed on 01/24/2024 which is past the timely filing deadline."

Response submitted by: Liberty Mutual Insurance

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.

Denial Reasons

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

- 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup.
- U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor is seeking payment for inpatient hospital services rendered in December of 2022. The insurance carrier reduced the claim based on Medicare payment policies.

   DWC Rule 28 TAC §133.307(c)(1) states:

   "Timeliness. A requestor 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 requestor 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 requestor 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 date of the service in dispute is December 15 - 23, 2022. The request for medical dispute resolution was received at the Division on January 29, 2024.

   Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requestor has waived their right to MFDR.

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 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

Signature	Medical Fee Dispute Resolution Officer	April 11, 2024 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.