



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Baptist Medical Center

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-24-1470-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

March 7, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 29, 2022 through June 9, 2022	0120	\$21472.00	\$0.00
May 29, 2022 through June 9, 2022	0250	\$213.00	\$0.00
May 29, 2022 through June 9, 2022	0300	\$23354.00	\$0.00
May 29, 2022 through June 9, 2022	0320	\$2903.00	\$0.00
May 29, 2022 through June 9, 2022	0450	\$10179.00	\$0.00
May 29, 2022 through June 9, 2022	0610	\$9253.00	\$0.00
May 29, 2022 through June 9, 2022	0636	\$15427.00	\$0.00
May 29, 2022 through June 9, 2022	0637	\$1899.00	\$0.00
May 29, 2022 through June 9, 2022	0730	\$885.00	\$0.00
May 29, 2022 through June 9, 2022	0921	\$3493.00	\$0.00
May 29, 2022 through June 9, 2022	WC ADJUSTMENTS	\$-78255.27	\$0.00
Total		\$10255.27	\$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 denied. However, despite the Hospital's efforts and Request for Reconsideration, Liberty Mutual has not rendered proper payment."

Amount in Dispute: \$10,255.27

Respondent's Position

"The bill for DOS 05/29/2022 to 06/09/2022 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 in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. The MFDR was filed on 03/07/2024 which is past the timely filing deadline."

Response submitted by: Liberty Mutual

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:

- 197 – (description not included on submitted explanation of benefits).
- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600.
- 16 – (description not included on submitted explanation of benefits).
- 165 – Valid DRG and/or Medicare number required for review. Re-submit bill with proper information for further processing.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

1. The requestor is seeking payment for emergency room/inpatient hospital stay rendered in May and June of 2022. The insurance carrier denied the claim based on lack of prior authorization

and missing information.

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 May 29, 2022 through June 9, 2022. The request for medical dispute resolution was received at the Division on March 7, 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

March 20, 2024

Date

Signature

Medical Fee Dispute Resolution Officer

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 electrónico CompConnection@tdi.texas.gov.