



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Texas Health Fort Worth

Respondent Name

Liberty Insurance Corp

MFDR Tracking Number

M4-24-1483-01

Carrier's Austin Representative

Box Number 60

DWC Date Received

March 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 22, 2022	111	18,800	\$0.00
November 6, 2022	111	20,225	\$0.00
November 6, 2022	250	1,331.13	\$0.00
November 6, 2022	258	800	\$0.00
November 6, 2022	272	1,026	\$0.00
November 6, 2022	300	35	\$0.00
November 6, 2022	301	11,678.25	\$0.00
November 6, 2022	302	915.04	\$0.00
November 6, 2022	305	2,913.75	\$0.00
November 6, 2022	306	1,096.75	\$0.00
November 6, 2022	320	1,101.25	\$0.00
November 6, 2022	351	3,048.50	\$0.00
November 6, 2022	360	8,218.50	\$0.00
November 6, 2022	370	2,787.50	\$0.00
November 6, 2022	450	3,049.75	\$0.00
November 6, 2022	483	2,669.50	\$0.00
November 6, 2022	636	4,373.23	\$0.00
November 6, 2022	710	1,098	\$0.00
November 6, 2022	730	937.50	\$0.00
November 6, 2022	761	308.50	\$0.00
November 6, 2022	771	336.50	\$0.00
Total		\$86,749.65	\$0.00

Requestor's Position

"The Carrier should not have denied the claim for lack of preauthorization because the Hospital received preauthorization approval from Blue Cross before it was informed this was a workers' compensation claim. The Carrier also should not have changed its reason for denial from entitlement to benefits to lack of preauthorization. The Carrier should reprocess and pay this claim in accordance with the Texas Workers' Compensation Rules."

Amount in Dispute: \$86,749.65

Respondent's Position

"We are in receipt of the above captioned medical fee dispute resolution. Pursuant to Rule 133.307 (c) (1) (A) a request for MFDR must be filed no later than one year after the dates of service in dispute. The provider is past the required timeframe laid out in Rule 133.307 and therefore this is not eligible for review by MFDR."

Response submitted by: Broadspire

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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- D49 – Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.
- W3 – In accordance with TDI-DWC Rule 134.804 , this bill has been identified as a request for reconsideration or appeal.
- D52 – Entitlement to benefits, not finally adjudicated.
- D00 – Based on further review, no additional allowance is warranted.

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 October/November 2022. The insurance carrier denied the claim based on lack of prior authorization.

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 October 22, 2022 through November 6, 2022. The request for medical dispute resolution was received at the Division on March 11, 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 26, 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, 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.