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
TEXAS HEALTH HEB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-24-0545-01

Carrier's Austin Representative
Box Number 60

MFDR Date Received
November 1, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 4, 2023	Hospital Outpatient	$4,033.75	0.00
	Total	$4,033.75	

Requester's Position

"Attached is a copy of an EOB, UB04, an itemized statement, medical records. We are resubmitting this claim for reconsideration of medical services charged on the UB04. The initial claim was sent electronically 4/21/2023 and denied under RESON [sic] CODE 5884 PROVIDER NOT WITHIN THE LIBERTY HEALTH CARE NETWORK..."

Amount in Dispute: $4,033.75

Respondent's Position

"The bill was reviewed and denied correctly as the provider does not have a contract with Liberty HCN and the provider did not received out of network approval by the Claims Case Manager.

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.
2. Texas Insurance Code (TIC) Chapter 1305 governs workers' compensation health care networks.

Denial Reason(s)

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment code(s):

- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and for appeals, corrected bills or questions, pertaining to the amount in the review allow column on this EOB, include a copy of the EOB, your reason for dispute, and any documentation you would like to us to review for reconsideration.
- 5884 – Provider is not within the Liberty Health care network (HCN) for this customer. Insurance Code 1305.004 (B) and Labor Code 401.011
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the disputed services out-of-network health care?
2. Under what conditions is the insurance carrier liable for out-of-network healthcare?
3. Is the insurance carrier liable for the disputed services?

Findings

1. The requestor, TEXAS HEALTH HEB, submitted medical fee dispute M4-24-0545-01 to the division for resolution according to 28 TAC §133.307. The dispute concerns outpatient hospital services provided by the requestor on November 1, 2023. Per the submitted documentation and from information known to the division, the injured employee's claim is within the Liberty, TX healthcare certified network. The requestor is not within the Liberty network, as a result, the requestor provided out-of-network health care to the injured employee.
2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code(TLC) legislation and rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of the TIC, Chapter 1305, are applicable to the DWC's ability to apply the TLC legislation and DWC rules for out-of-network health care. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by

§1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §1305.006 titled *INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE,* states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

(1) Emergency Care;

(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to §1305.103."

3. The requestor therefore has the burden to prove that the condition(s) outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor has submitted insufficient documentation to prove that any of the conditions outlined in TIC §1305.006 applied to the disputed services.

   DWC concludes that the requestor failed to demonstrate that any of the conditions of TIC §1305.006 were met in this dispute, As a result, DWC finds that the insurance carrier is not liable for the out-of-network care in dispute.

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. The Division concludes that the insurance carrier is not liable for the disputed services.

Order

Based on the submitted information, pursuant to Texas Labor Code 413.031, the DWC hereby determines the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

[redacted] November 20, 2023

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 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 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 512-804-4812.