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
METHODIST HEALTH SYSTEMS

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-25-2828-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 12, 2024 to February 14, 2024	Hospital Outpatient	$5,931.72	$0.00

Requester's Position

"REQUESTING REVIEW OF NETWORK AUTH DENIAL."

Amount in Dispute: $5,931.72

Respondent's Position

"Additionally, the claimant is in a certified healthcare network. Medical Fee Disputes involving a provider within a certified healthcare network are resolved through the network itself."

Response Submitted by: Flahive, Ogden & Latson

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. The Texas Insurance Code (TIC) Chapter 1305 sets out the general provisions for workers' compensation health care networks.
4. 28 TAC §§10.120 through 10.122 sets out the workers compensation health care networks complaints guidelines.
5. 28 TAC §141.1 sets out the guidelines for dispute resolution—benefit review conference.

Denial Reason(s)

The insurance carrier 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 does not warrant a separate payment of the payment status indicator determines the service is packaged or excluded from payment
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 5916 – Provider is not within the Coventry Health Care Network (HCN) for this Customer. TX Insurance Code 1305.004 (B) and Labor Code 401.011
- 847 – In accordance with OPPS Guidelines, the billed revenue codes require HCPCS/CPT coding. No separate payment is recommended for a non-package revenue code

Issues

1. Were the disputed services provided by the requester out-of-network healthcare?
2. Is the insurance carrier liable for the out-of-network healthcare in this case?

Findings

1. The requester, Methodist Health Systems, submitted medical fee dispute M4-25-2828-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves outpatient hospital services rendered on February 12, 2024 to February 14, 2024.

Based on the documentation submitted and information available to DWC, the injured

employee's claim is subject to the Liberty Healthcare Certified Network. At the time of service, the requester was not a participating provider in this network and therefore rendered out-of-network care. DWC has jurisdiction to resolve such disputes.

2. The requester seeks reimbursement based on provisions in the TLC and applicable rules, including 28 TAC §133.307. Pursuant to Texas Insurance Code (TIC) §1305.153(c), out-of-network providers who deliver care as described in §1305.006 are reimbursed as provided by the Texas Workers' Compensation Act and relevant DWC rules.

   TIC §1305.006 outlines the circumstances under which an insurance carrier is liable for out-of-network care:

   - (1) Emergency care
   - (2) Care provided for an employee residing outside any network service area
   - (3) Care provided by an out-of-network provider pursuant to a referral approved by the network under §1305.103

   The requester did not assert that the services in question meet any of the criteria under §1305.006.

   The services were denied by the carrier with the reduction code indicated above. To establish carrier liability under §1305.006(3), the requester must show an approved referral from the network. While the requester submitted documentation with the MFDR dispute, no copy of a network-approved referral was included. Therefore, the requester did not meet the requirement for an approved out-of-network referral under TIC §§1305.006(3) and 1305.103.

   Additionally, the requester did not sufficiently establish that the disputed services constituted emergency care or that the care was provided to the injured employee residing outside any network service area. Under 28 TAC §133.307(c)(2)(N), a valid position statement must explain:

   - Why the disputed fees should be paid…
   - How the TLC and DWC rules apply to the fee dispute
   - How the documentation supports the requester's position

   The requester's statement failed to demonstrate any of the following.

   - That the care provided to the in-network injured employee met the definition of emergency care as outlined in TIC §1305.004(13);
   - That the care provided to the in-network injured employee residing outside any network service area;
   - That the care provided by the out-of-network provider was pursuant to a referral approved by the network under 1305.103.

The burden of proof lies with the requester to establish that one or more of these circumstances in TIC §1305.006 apply, thereby making the insurance carrier liable for the disputed services. The requester's documentation is insufficient to support that any of these circumstances were met.

Conclusion

After a review of all the submitted evidence, DWC concludes that the requester failed to meet the burden of proof to establish that any of the circumstances in TIC §1305.006 apply to this dispute. Accordingly, the DWC finds the insurance carrier is not liable for the out-of-network services in question.

Order

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

Authorized Signature

[redacted] July 30, 2025

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.