



## Medical Fee Dispute Resolution Findings and Decision General Information

**Requester Name**  
METHODIST HEALTH  
SYSTEM

**Respondent Name**  
LM INSURANCE CORP

**MFDR Tracking Number**  
M4-25-2994-01

**Carrier's Austin Representative**  
Box Number 60

**MFDR Date Received**  
July 22, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 7, 2024	Code 72100	\$200.81	\$0.00
<b>Total</b>		\$200.81	\$0.00

### Requester's Position

"Seeking review of network authorization denial."

**Amount in Dispute:** \$200.81

### 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 \(TLC\) §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):

- 5884 – Provider is not within the Liberty Health care network (HCN) for this customer. Insurance Code 1305.004 (B) and Labor code 401.011 (5884)

## **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 SYSTEM, submitted medical fee dispute M4-25-2994-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves Code 72100 - Radiology.

Based on the documentation submitted and information available to DWC, the injured employee's claim is subject to the Liberty Health Care Certified Network. At the time the services were rendered, the requester was not a participating provider in this certified network. Therefore, the services were provided on an out-of-network basis.

The requester contends that "seeking review of network authorization denial" and asserts that this entitles them to reimbursement under the Texas Labor Code (TLC) and applicable DWC rules. The DWC has jurisdiction to review and resolve medical fee disputes of this nature.

2. The requester seeks reimbursement pursuant to the Texas Labor Code (TLC) and applicable regulations, including 28 TAC §133.307. Liability for out-of-network care is governed by the Texas Insurance Code (TIC) §1305.006, which specifies the limited circumstances under which an insurance carrier is responsible for such care.

TIC §1305.006 identifies three scenarios that may impose liability on an insurance carrier for out-of-network services:

1. Emergency care.
2. Care provided to an employee residing outside any network service area; and

3. Care delivered by an out-of-network provider following a network-approved referral under §1305.103.

Upon review, the Division found no supporting documentation substantiating that the services qualified as emergency care under subsection (1). Additionally, the dispute lacked a valid position statement as required by 28 TAC §133.307(c)(2)(N), which must clearly explain:

- Why the disputed fees should be paid.
- How the relevant TLC and Division of Workers' Compensation (DWC) rules apply to the dispute; and
- How the submitted evidence supports the requester's position.

The requester's statement failed to adequately demonstrate that the care met the statutory definition of "emergency care" as set forth in TIC §1305.004(13). Moreover, the supporting documentation was insufficient to substantiate a claim under this provision.

Regarding subsection (2), the Division found no evidence that the injured employee resided outside the network's service area. Consequently, the requirements to establish liability under this subsection were not satisfied.

With respect to subsection (3), the Division noted no documents confirming a network-approved referral was submitted. Thus, the criteria for liability under this subsection was not met.

### **Conclusion**

After careful consideration of the submitted documentation, the Division concludes that the requester has not met the burden of proof to establish that the disputed services qualify under any of the circumstances outlined in TIC §1305.006. Specifically:

- No evidence was provided to support a claim of emergency care.
- No documentation demonstrated that the injured employee resided outside the network's service area; and
- No network-approved out-of-network referral was presented.

Accordingly, the requester has not shown that the insurance carrier is liable for payment of the out-of-network services. Therefore, the dispute is resolved in favor of the insurance carrier.

### **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**

August 11, 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](http://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](mailto: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.