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
LM INSURANCE CORP

MFDR Tracking Number
M4-25-3080-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
July 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 5, 2024	Code 72040 – radiology	$165.97	$0.00

Requester's Position

"Requesting review of NETWORK authorization denial."

Amount in Dispute: $165.97

Respondent's Position

"This bill for DOS 02/05/2024 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 7/21/2025 which is greater than time allotted."

Response Submitted by: Liberty Mutual

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. 28 TAC §141.1 sets out the guidelines for dispute resolution—benefit review conference.

Denial Reasons

The insurance carrier reduced or denied payment for the disputed services with the following claim adjustment codes:

- 5884 – Provider is not within the Liberty Health Care Network (HCN) for this customer. Insurance Code 1305.004 (B) an Labor Code 401.011

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 M4-25-3080-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves radiology charges, billed under CPT code 72040 rendered on February 5, 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 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 "requesting 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. According to 28 Texas Administrative Code (TAC) §133.307(c)(1), a request for Medical Fee Dispute Resolution (MFDR) must be submitted no later than one year after the date of the disputed service, except in certain limited circumstances outlined in subsection (B) of the same provision.

Specifically, 28 TAC §133.307(c)(1)(B) allows for a later filing if one of the following conditions applies:

(i) A related dispute concerning compensability, extent of injury, or liability under Labor Code Chapter 410 has been filed. In such cases, the medical fee dispute must be submitted within 60 days after the requester receives the final decision on compensability, extent of injury, or liability, including all appeals.

(ii) A dispute regarding medical necessity has been filed. Here, the medical fee dispute must be filed within 60 days after the requester receives the final decision on medical necessity, including all appeals, for the specific health care services in question that were previously denied by the insurance carrier based on medical necessity.

(iii) The dispute arises from a refund notice issued following a division audit or review. In this situation, the medical fee dispute must be filed within 60 days after the requester receives the refund notice.

In this case, radiology services were provided on February 5, 2024. The Division received the MFDR request on July 21, 2025, which is more than one year after the date of service. Upon review of the documentation provided, there is no indication that the dispute falls within any of the exceptions described in 28 TAC §133.307(c)(1)(B).

The Division finds the requester has not established that reimbursement is due.

Conclusion

The Division concludes that the requester failed to file the MFDR request within the required timeframe and has consequently waived the right to pursue Medical Fee Dispute Resolution for this claim.

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

Order

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

Authorized Signature

[redacted] [redacted] October 24, 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.