TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Methodist Health Systems

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-25-3114-01

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 21, 2024	Radiology	$200.81	$0.00

Requester's Position

"Requesting review of network authorization denial."

Amount in Dispute: $200.81

Respondent's Position

"As a good faith gesture, the bill was reviewed and denied correctly as the provider does not have a contract with Liberty HCN and the provider did not receive 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) §133.305 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

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

- 5884 TX - 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 requester eligible for DWC medical fee dispute resolution for the services in question?

Findings

1. The requester, Methodist Health Systems, submitted medical fee dispute M4-25-3114-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves radiology services provided in a hospital on June 21, 2024.

   Based on the submitted documentation and information available to the Division of Workers' Compensation (DWC), the injured employee's claim falls under the Liberty Healthcare Network. At the time the services were provided, the requester was not a participating provider within this certified network. Consequently, the services were rendered on an out-of-network basis. The DWC has jurisdiction to review and resolve medical fee disputes of this nature. Accordingly, the disputed services are reviewed in accordance with the applicable rules and guidelines.

2. The requester is seeking reimbursement for medical services rendered on June 21, 2024. 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, the medical services were rendered on June 21, 2024. The Division received the MFDR request on July 22, 2025, which is more than one year after the date(s) 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 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. 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 requester is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		August 12, 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.