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

General Information

Requester Name
Texas Health of Arlington

Respondent Name
Liberty Insurance Corp.

MFDR Tracking Number
M4-25-3360-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
August 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 2, 2025	97110, and 97140		$0.00
April 7, 2025	97110, and 97140		$0.00
April 9, 2025	97110, and 97140		$0.00
April 14, 2025	97110, and 97140		$0.00
April 16, 2025	97110, and 97140		$0.00
April 28, 2025	97110, and 97140		$0.00
	Total	$947.60	$0.00

Requester's Position

A complete claim with medical records was submitted on 5/10/20258, however, this claim payment was denied 'THE PROVIDER IS NOT WITHIN THE LIBERTY HEALTH CARE NETWORK FOR THIS CUSTOMER.' Our representative… spoke with… with Liberty Mutual and she gave a verbal authorization for the services billed on this claim. Attached is a complete claim… Please review the medical records and find the claimant's injury occurred during the course and scope of their employment."

Amount in Dispute: $947.60

Respondent's Position

"The bill was reviewed and denied correctly as the provider does not have a contact with Liberty HCN, and the provider did not receive out of network approval by the Claims Case Manager. Attached is a printout from our Provider Referral Services Site showing the TIN is not found as participating."

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 Reasons

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

- 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.
- X598 – Claim has been re-evaluated based on additional documentation submitted, no additional payment due.

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. Texas Health Arlington submitted Medical Fee Dispute M4-25-3360-01 to the Division of Workers' Compensation (DWC) for resolution pursuant to 28 TAC §133.307. The dispute concerns outpatient physical therapy services provided over six dates between April 2 and April 28, 2025.

   Based on the documentation submitted and information available to DWC, the injured employee's claim is subject to the Liberty Healthcare Network (HCN). 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 they "spoke with… with Liberty Mutual and she gave a verbal authorization for the services billed on this claim," and asserts that this entitles them to reimbursement under the Texas Labor Code (TLC) and applicable DWC rules. The requester claims that prior authorization was obtained, the requester is still required to obtain an out-of-network-referral before the services are rendered to an in-network claimant.

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. The DWC has jurisdiction to review and resolve medical fee disputes of this nature.

   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 that the services in question qualified as emergency care under subsection (1).

   Regarding subsection (2), there was no evidence to support that the injured employee resided outside the network's service area. Therefore, the criteria to establish liability under this subsection were not met.

   With respect to subsection (3), the Division found no documentation to support that a referral approved by the network was submitted for consideration. Accordingly, the requirements for liability under this subsection were also not satisfied.

For these reasons, the Division concludes that the requester is not entitled to reimbursement for the disputed services.

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.

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

		August 29, 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.