



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Hand & Wrist Center of Houston

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-25-1409-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 19, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 30, 2024	73140	\$95.20	\$0.00
July 30, 2024	99080	\$15.00	\$0.00
Total		\$110.20	\$0.00

Requester's Position

"As clearly stated in the medical record, after personally examining this patient, I have determined that this injured worker's medical condition, indicated by and matching the ICD10 code on the CMS-1500 claim form, was a medical emergency condition on this date of service, as defined in the Texas Administrative Code... Under Texas law, no preauthorization or network participation by me, the medical provider examining and treating the patient, is required when the injured worker is diagnosed with a medical emergency condition(s) such as this patient sustained, and for which I rendered the usual, customary, and necessary treatment(s) indicated by CPT code(s) in my medical record and on the CMS-1500 claim form."

Amount in Dispute: \$110.20

Respondent's Position

"This claim is in the Work Well, TX network. Texas Mutual has reviewed the network provider directory for the provider's name and tax identification number and confirmed HAND & WRIST CENTER OF HOUSTON DEPT as a participant for physical therapy and occupational only, the treatment rendered does not fall under these categories.

"As an out-of-network provider, approval is required before rendering service or treatment. Texas Mutual did not receive or find any evidence of out-of-network approval obtained by the requestor."

Response Submitted by: Texas Mutual Insurance Company

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) §[133.307](#) sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code (TIC) [Chapter 1305](#) governs workers' compensation health care networks.
3. Texas Labor Code (TLC) Sections [413.011](#) (d-1) to (d-6) [expired] and 413.0115, as well as former division Rule at 28 TAC §[133.4](#) sets out certain provisions related to informal and voluntary insurance networks.
4. TLC §[413.031](#) entitles health care providers to a review of services if payment is reduced.
5. [28 TAC §133.240](#) sets out procedures for medical bill processing.

Denial Reason(s)

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

- 243 - SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
- W3 & 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- DC4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION.
- DC7 - DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY WORKWELL, TX NETWORK.
- D27 - PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT.

Issues

1. Are the disputed services out-of-network health care?
2. If the disputed services are out of network, is the insurance carrier liable for the disputed services under TIC §1305.006?

Findings

1. The requestor, Hand and Wrist Center of Houston, submitted medical fee dispute M4-25-1409-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns a radiologic examination and a Work Status Report provided by the requestor on July 30, 2024. Per the submitted documentation, the injured employee's claim is within the WorkWell Certified Healthcare Network.

The insurance carrier states in pertinent part, "...confirmed HAND & WRIST CENTER OF HOUSTON DEPT as a participant for physical therapy and occupational only, the treatment rendered does not fall under these categories." The respondent submitted documentation to support the assertion that Hand and Wrist Center of Houston is contracted with Align Network for physical and occupational therapy only.

The requestor seeks reimbursement for a radiologic examination and a Work Status Report billed under CPT codes 73140 and 99080 respectively, rendered on July 30, 2024. DWC finds that the services in this dispute are not related to physical and occupational therapy services.

Per TLC §413.011(d-1) to (d-6) and §413.0115, as well as 28 TAC §133.4, other than for certain pharmacy, durable medical equipment, or home health care services, insurance carriers may not contract with informal or voluntary insurance networks to provide workers' compensation services effective January 1, 2011, unless such a former informal or voluntary network was certified as a workers' compensation health care network under Chapter 1305, Insurance Code, no later than January 1, 2011.

Further, the injured employee must be enrolled in the certified workers' compensation network and the certified workers' compensation network must be named on the explanation of benefits, per 28 TAC §133.240(f)(15). Based on the information provided by Texas Mutual Insurance Company, the injured employee is enrolled in the WorkWell network certified in accordance with Texas Insurance Code Chapter 1305.

Based on the information presented by the respondent for review, the division concludes the respondent has failed to support that the healthcare provider is enrolled in the WorkWell certified healthcare network. The respondent did, however, submit sufficient documentation to support that the injured employee is enrolled in WorkWell, a certified worker's compensation HCN.

The requestor was not in the WorkWell network when the date of service was rendered. As a result, the requestor provided out-of-network health care to the injured employee.

The Requestor, having provided out-of-network services, asserts that the care provided was "emergency care" such that network-based restrictions are inapplicable, and the respondent/carrier is required to pay in accordance with the TLC and DWC rules. A medical fee dispute of this nature is within the jurisdiction of DWC.

2. The requestor submitted the dispute requesting reimbursement for the disputed services as governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of the TIC, Chapter 1305, are applicable to DWC's ability to apply the TLC legislation and DWC rules for out-of-network health care. TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by §1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

TIC §1305.006 titled *INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE* states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network healthcare that is provided to an injured employee:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to §1305.103."

The requestor therefore has the burden to prove that the exceptions outlined in the TIC §1305.006 were met for the insurance carrier to be liable for the disputed services. The requestor contends that the disputed services were provided for emergency care in TIC §1305.006(1). TIC §1305.006(2) and (3) were not shown to be applicable in this case.

DWC concludes that the provider failed to meet its burden of proof to establish that the dates of service in dispute were emergency care. TAC §133.307(c)(2)(N) requires a position statement including: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and DWC rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue. The position statement did not explain how the care

provided on the dates of service were emergency care under TIC §1305.006. Furthermore, for the dates of service at issue, the documentation provided was not sufficient to show that the care provided was for a medical emergency as defined in TIC §1305.004(13). Because the treatment for these dates of service was not shown to be emergency care, the insurance carrier is not liable for this non-network care under TIC §1305.006.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered. DWC 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 requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	April 14, 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.