



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Methodist Health Systems

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-25-2310-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 20, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 2, 2024	Clinic Visit	\$251.90	\$0.00

Requester's Position

"Requesting reconsideration of timely filing."

Amount in Dispute: \$251.90

Respondent's Position

"This claim is in the Texas Star Network. Texas Mutual has reviewed the network provider directory for the provider's name and tax identification number and confirmed no record of METHODIST DALLAS MEDICAL CENTER as a participant. 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. ... Since this fee reimbursement dispute involves a network requirement under the Insurance Code rather than the Labor Code, Texas Mutual believes this dispute is outside the jurisdiction of DWC MDR."

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.

Denial Reason(s)

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

- 219 – Based on extent of injury.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-P12 - Workers' compensation jurisdictional fee schedule adjustment.
- CAC-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.
- CAC-W3, 350 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.
- 714 - Accurate license, CPT/HCPCS, NDC#, dates, units, days supply, modifiers are required. Submit corrections W/I 95 days from DOS.
- 246 - The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
- 714 - Accurate coding is essential for reimbursement CPT billed incorrectly services are not reimbursable as billed.

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?
3. Is the requestor entitled to reimbursement for the service in dispute?

Findings

1. Methodist Health Systems, the requestor, submitted medical fee dispute M4-25-2310-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves the non-payment of an office visit, billed under CPT code 99213, and provided by Methodist Health Systems on July 2, 2024. According to the submitted documentation and information available to DWC, the injured employee's claim is within the Texas Star Network. However, the requestor was not part of the network on the date of service. Consequently, the requestor delivered out-of-network medical care to the injured employee.
2. The requestor submitted a dispute seeking reimbursement for the contested services, citing the Texas Labor Code (TLC) and its governing rules, including 28 TAC §133.307. The provisions outlined in the Texas Insurance Code (TIC), Chapter 1305, apply to the Division of Workers' Compensation's (DWC) authority to enforce TLC legislation and DWC rules concerning out-of-network health care. Specifically, TIC §1305.153(c) states that "Out-of-network providers who provide care as described in §1305.006 shall be reimbursed in accordance with 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."

Rule §133.307(c)(2)(N) requires a position statement to include: (i) the requestor's rationale for why the disputed fees should be reimbursed or refunded; (ii) an explanation of how the Labor Code and DWC rules, including fee guidelines, relate to the disputed fees; and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue.

Accordingly, the requestor has the burden of demonstrating that one or more exceptions under TIC §1305.006 apply, establishing the insurance carrier's liability for the disputed services. The position statement did not clarify how the care provided on the disputed date qualifies as emergency care under TIC §1305.006. Moreover, the documentation submitted failed to substantiate that the care on the date of service constituted a medical emergency as defined by TIC §1305.004(13).

Additionally, the requestor did not provide sufficient evidence that the injured employee resides outside the service area of any network or that the services were rendered pursuant to an approved referral from the treating physician under §1305.103.

Because the treatment on the date of service, July 2, 2024, does not meet any of the exceptions outlined in TIC §1305.006, the insurance carrier is not liable for this out-of-network care.

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. The Division concludes that the insurance carrier is not liable for the disputed services.

Order

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

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 11, 2025
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 prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.