



Medical Fee Dispute Resolution Findings and Decision General Information

Requester Name

Workers Clinic Inc. SA

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-25-2927-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 17, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 26, 2024	99204-25	\$415.00	\$0.00
December 26, 2024	99080-73	\$15.00	\$0.00
Total		\$430.00	\$0.00

Requester's Position

"The original claim, submitted for services rendered on 12/26/2024, was denied by Texas Mutual on 03/10/2025. In response, we submitted an appeal clarifying that the rendering provider is part of the Texas Mutual Contract Network."

Amount in Dispute: \$430.00

Respondent's Position

"This claim is in the WorkWell, TX network. Texas Mutual has reviewed the network provider directory for the provider's name and tax identification number and confirmed no record of WORKERS CLINIC INC 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."

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):

- CAC-W3, 350 - In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-18 - Exact duplicate claim/service.
- CAC-193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-243 - Services not authorized by network/primary care providers.
- 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.
- 224 – Duplicate charge.

Issues

1. Are the disputed services out-of-network health care?
2. Under what conditions is the insurance carrier liable for out-of-network healthcare?
3. Is the insurance carrier liable for the disputed services?

Findings

1. The requester, Workers Clinic Inc SA, submitted medical fee dispute M4-25-2927-01 to the division for resolution according to 28 TAC §133.307. The dispute concerns an office visit and a work status report provided by the requester on December 26, 2024. Per the submitted documentation and from information known to the division, the injured employee's claim is within the Texas Mutual WorkWell healthcare certified network. The requester is not within the Texas Mutual WorkWell network, as a result, the requester provided out-of-network health care to the injured employee.
2. The requester 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 the 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."

3. The requester therefore has the burden to prove that the conditions outlined in TIC 1305.006 were met with the insurance carrier to be liable for the disputed services. The requester has submitted insufficient documentation to prove that any of the conditions outlined in TIC §1305.006 applied to the disputed services.

DWC concludes that the requester failed to demonstrate that any of the conditions of TIC §1305.006 were met in this dispute, as a result, DWC finds that the insurance carrier is not liable for the out-of-network care in dispute.

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 4, 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.