TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Hand & Wrist Center of Houston

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-26-0174-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
September 18, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 10, 2024	29130	$114.07	$0.00
September 10, 2024	73140	$95.20	$0.00
September 10, 2024	99080	$15.00	$0.00
	Total	$224.27	$0.00

Requestor'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…"

Amount in Dispute: $224.27

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 HAND & WRIST CENTER OF HOUSTON OR Dr. Mark Henry as a participant."

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 Medical Fee Dispute Resolution (MFDR) requests.

Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following claim adjustment codes:

- CAC-P12 WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- CAC-W3 IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 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. FOR INFORMATION CALL (888) 532-5246.
- D27 - PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT. FOR NETWORK INFORMATION CALL 844-867-2338
- 248 - DWC-73 IN EXCESS OF THE FILING REQUIREMENTS; NO CHANGE IN WORK STATUS AND/OR RESTRICTIONS; REIMBURSEMENT DENIED PER RULE 129.5
- 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Has the requestor waived its right to medical fee dispute resolution (MFDR)?

Findings

1. The requestor is seeking reimbursement for services rendered on disputed date of service, September 10, 2024. The medical fee dispute resolution (MFDR) request form, DWC060, was received by the division on September 18, 2025.

   28 (TAC) §133.307 (c)(1)(A) sets out the timely filing procedures for Medical Fee Dispute Resolution (MFDR) requests. It requires a request for MFDR that does not meet any exceptions listed in 28 TAC §133.307(c)(1)(B) to be filed no later than one year after the dates of service in dispute. 28 TAC §133.307(c)(1)(B) sets out those exceptions, stating, "A request may be filed later than one year after the date(s) of service if:

   (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
   (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or
   (iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice. "

   The disputed date of service is September 10, 2024. On September 18, 2025, DWC received the DWC060 request form. The disputed service does meet any of the exceptions specified in 28 TAC 133.307(c)(1)(B), according to an examination of the submitted documentation. DWC finds that more than a year has passed since the disputed date of service and the request for medical fee dispute resolution was submitted.

   According to DWC, the requestor has forfeited its right to MFDR and is not eligible for Medical Fee Dispute Resolution review.

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 finds the requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature:

		October 6, 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 3 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 1-800-252-7031, opción 3 o correo electronico CompConnection@TDI.Texas.gov