



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Hand and Wrist Center of Houston

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-0496-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

October 21, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 19, 2025	73140	\$95.20	\$0.00
May 19, 2025	99080-73	\$15.00	\$0.00
Total		\$110.20	\$0.00

Requester's Position

"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 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 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. Our position is that no payment is due."

Response Submitted by: Texas Mutual Insurance Company

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 with the following claim adjustment codes:

- 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. For information call (888) 532-5246.
- DC7 – Duplicate appeal. Network contract applied by WorkWell, TX network.
- D27 – Provider not approved to treat WorkWell, TX network claimant.

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. The requester, Hand and Wrist Center of Houston, submitted medical fee dispute (M4-26-0496-01) to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves the non-payment of a work status report, and an x-ray exam of the finger, rendered on May 19, 2025.

Based on the documentation submitted and information available to DWC, the injured employee's claim is subject to the WorkWell Certified Healthcare Network. At the time of

service, the requester was not a participating provider in this network and therefore rendered out-of-network care.

The requester argues that the care provided constituted emergency care, which is exempt from network restrictions, thereby making the insurance carrier liable for payment under the Texas Labor Code (TLC) and DWC rules. DWC has jurisdiction to resolve such disputes.

2. The requester seeks reimbursement based on provisions in the TLC and applicable rules, including 28 TAC §133.307. Pursuant to Texas Insurance Code (TIC) §1305.153(c), out-of-network providers who deliver care as described in §1305.006 are reimbursed as provided by the Texas Workers' Compensation Act and relevant DWC rules.

TIC §1305.006 outlines the circumstances under which an insurance carrier is liable for out-of-network care:

- (1) Emergency care
- (2) Care provided to an employee residing outside any network service area
- (3) Care provided by an out-of-network provider pursuant to a referral approved by the network under §1305.103

Upon review, the Division found no supporting documentation substantiating that the services qualified as emergency care under subsection (1). Additionally, the dispute lacked a valid position statement as required by 28 TAC §133.307(c)(2)(N), which must clearly explain:

- Why the disputed fees should be paid.
- How the relevant TLC and Division of Workers' Compensation (DWC) rules apply to the dispute; and
- How the submitted evidence supports the requester's position.

The requester's statement failed to adequately demonstrate that the care met the statutory definition of "emergency care" as set forth in TIC §1305.004(13). Moreover, the supporting documentation was insufficient to substantiate a claim under this provision.

Regarding subsection (2), the Division found no evidence that the injured employee resided outside the network's service area. Consequently, the requirements to establish liability under this subsection were not satisfied.

With respect to subsection (3), the Division noted insufficiently confirming a network-approved referral was submitted. Thus, the criteria for liability under this subsection was not met.

Additionally, the requester did not sufficiently establish that the disputed services constituted emergency care. Under 28 TAC §133.307(c)(2)(N), a valid position statement must explain:

- Why the disputed fees should be paid
- How the TLC and DWC rules apply to the fee dispute
- How the documentation supports the requester's position

The requester's statement failed to demonstrate that the care provided to the in-network injured employee met the definition of emergency care as outlined in TIC §1305.004(13). Furthermore, the supporting documentation was insufficient to substantiate this claim.

Conclusion

After a review of all the submitted evidence, DWC concludes that the requester did not meet the burden of proof to establish that the services were emergency care or otherwise qualified for a review by Medical Fee Dispute Resolution. As a result, the insurance carrier is not liable for the out-of-the-network services provided.

Order

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

Authorized Signature

		November 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. The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, 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 the Division. **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.