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

Requester Name
Hand & Wrist Center of Houston

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-26-1029-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 11, 2025	99214	$322.50	$0.00
August 11, 2025	99080	$15.00	$0.00
August 11, 2025	99456	$0.00	$0.00
	Total	$337.50	$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: $337.50

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 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 requester… 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 §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. TLC §413.031 entitles health care providers to a review of services if payment is reduced.

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.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 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.
- 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. FOR

NETWORK INFORMATION CALL 844-867-2338

- 249 - DWC-73 NOT SUBMITTED; NOT PROPERLY COMPLETED AND/OR MISSING REQUIRED SIGNATURE OR MISSING MODIFIER; REIMBURSEMENT DENIED PER RULE 129.5

Issues

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

Findings

1. A review of the DWC060, Medical Fee Dispute Resolution (MFDR) Request form, submitted by the requester, finds that the following procedures codes are listed in the "Table of Disputed Services":

   99214 in dispute for $322.50

   99080 in dispute for $15.00

   99456 in dispute for $0.00

   A review of the submitted documentation finds that the medical bills submitted include charges for procedure codes 99214 and 99080 only. In its document review, DWC finds no evidence that a medical bill including a charge for procedure code 99456 was submitted. The requester is not seeking reimbursement for procedure code 99456. Therefore, DWC finds that the only procedure codes to be reviewed and/or addressed in this MFDR review are 99214 and 99080.

2. The requester, Hand and Wrist Center of Houston submitted medical fee dispute M4-26-1029-01 to DWC for resolution according to 28 TAC §133.307. The dispute concerns an office visit and a work status report provided by the requester on August 11, 2025. Per the submitted documentation, the injured employee's claim is within the WorkWell Certified Healthcare Network.

   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 network.

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

   The Requester, 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.

3. 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 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 requester 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 requester contends that the disputed services were provided for emergency care in TIC §1305.006(1).

   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 requester'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 requester's position for each disputed fee issue. The position statement did not explain how the care provided on the dates of service was 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 requester 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 requester is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		December 18, 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.