



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

GOLDTHWAITE HEALTH & REHAB

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-26-1241-01

**Insurance Carrier's Austin Representative**

BOX 54 Texas Mutual Insurance Co

**DWC Date Received**

December 25, 2025

### Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
January 19, 2024 – January 31, 2024	Physical and Occupational Therapy	\$12,592.89	\$0.00
<b>Total</b>		\$12,592.59	\$0.00

### Requester's Position

"Reaching out with an explanation regarding these document submission. Claim [claim number] was denied due to provider out of network and no authorization."

**Amount In Dispute:** \$\$12,592.59

### Respondent's Position

"Texas Mutual has reviewed the DWC-60 submitted by GOLDTHWAITE HEALTH & REHAB CENTER ... One year from disputed date of service 01/9/2024-01/31/2024 would have been 01/31/2025."

**Response Submitted By:** Texas Mutual

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [133.305](#) sets out the procedures for resolving medical disputes.
3. Texas Insurance Code 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 TAC141.1](#) sets out the guidelines for dispute resolution—benefit review conference.

### Adjustment Reasons

The insurance carrier denied payment for the disputed services with the following reasons:

1. CAC-243 – Services not authorized by network/primary care providers
2. D27 – Provider not approved to treat WorkWell, TX Network Claimant. For network information call 844-864-2338

### Issues

1. What is DWC considering in this medical fee dispute?
2. Were the disputed services provided by the requester out-of-network healthcare?
3. Is the insurance carrier liable for the out-of-network healthcare in this case?

### Findings

1. Review of the submitted documentation requester is seeking reimbursement for \$12,592.89. Services billed are Physical and Occupational Therapy performed on January 19, 2024 – January 31, 2024. Insurance carrier denied the services with denial codes CAC-243 – Services not authorized by network/primary care providers and D27 – Provider not approved to treat WorkWell, TX Network Claimant. For network information call 844-864-2338. The insurance carrier made \$0.00 reimbursement for services in dispute.
2. The requester, Goldtwaithe Health & Rehab, submitted medical fee dispute M4-26-1241-01 to the Division of Workers' Compensation (DWC) for resolution under 28 TAC §133.307. The dispute involves Physical and Occupational Therapy rendered on January 19, 2024 – January 31, 2024.

Based on the documentation submitted and information available to DWC, the injured

employee's claim is subject to the WorkWell Healthcare Certified 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.

3. 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

The requester asserts that the services in question meet the criteria for emergency care under §1305.006(1). No claims were made under subsections (2) or (3).

The services were denied by the carrier with reduction code CAC-243 – Services not authorized by network/primary care providers and D27 – Provider not approved to treat WorkWell, TX Network claimant. For network information call 844-867-2338. To establish carrier liability under §1305.006(3), the requester must show an approved referral from the network. While the requester stated that [quote the requesters position relevant to this section], the documentation included a [identify the documentation that was included if any], however no copy of a network-approved referral was included. Therefore, the requester did not meet the requirement for an approved out-of-network referral under TIC §§1305.006(3) and 1305.103.

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

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

### **Order**

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to \$0.00 reimbursement for the disputed services. Click or tap here to enter text.

### **Authorized Signature**

  
Signature

  
Medical Fee Dispute Resolution Officer

January 9, 2026  
Date

### **Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC Section [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](http://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 800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto: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 this Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).