TDI Division of Workers' Compensation
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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
M4-26-1705-01

Insurance Carrier's Austin Representative
BOX 54 Texas Mutual Insurance Co

DWC Date Received
February 18, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
April 11, 2025	73140	$95.20	$0.00
April 11, 2025	99080-73	$15.00	$0.00
	Total	$110.20	$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: $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 DEPT A 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

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. Texas Insurance Code (TIC) Chapter 1305 sets out the general provisions for workers' compensation health care networks.
3. Labor Code Section 413.031 entitles health care providers to a review of services if payment is reduced.

Adjustment Reasons

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

1. 243 – SERVICES NOT AUTHORIZED BY NETWORK/PRIMARY CARE PROVIDERS.
2. W3 & 350 - IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
3. 18 – EXACT DUPLICATE CLAIM/SERVICE.
4. 193 - ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
5. DC27 - PROVIDER NOT APPROVED TO TREAT WORKWELL, TX NETWORK CLAIMANT.
6. DC4 - NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER RECONSIDERATION
7. DC7 - DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY WORKWELL, TX NETWORK.

Issues

1. What is DWC considering in this medical fee 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. In the review of this medical fee dispute, M4-26-1705-01, DWC will consider whether the services in question were rendered as out-of-network health care.

   If DWC determines that the disputed services were rendered as out-of-network health care, DWC will then consider whether the insurance carrier is liable for payment of the disputed professional medical services in accordance with TIC Chapter 1305.006, which sets out general provisions for workers' compensation health care networks.

2. The requester, Hand and Wrist Center of Houston submitted medical fee dispute M4-26-1705-01 to DWC for resolution according to 28 TAC Section 133.307. The dispute concerns a radiographic service and a Work Status Report provided by the requester on April 11, 2025. Per information known to DWC, the injured employee's claim is within the WorkWell Certified Healthcare Network. It is also known to DWC that the requester was not in the network at the time of the date of service(s) in dispute. 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 governed by the Texas Labor Code (TLC) legislation and rules, including 28 TAC Section 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 Section 1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   TIC Section 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 Section 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 Section 1305.006(1). TIC §1305.006(2) and (3) were not shown to be applicable in this case.

DWC concludes that the provider failed to meet its burden of proof to establish that the date of service in dispute was emergency care. TAC Section 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 Section 1305.006. Furthermore, for the date 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 Section 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 Section 1305.006.

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 concludes that the insurance carrier is not liable for the disputed services.

Order

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

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 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. 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.

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 electronico CompConnection@tdi.texas.gov.