TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Cardio Specialists of North Texas

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-26-2681-01

Insurance Carrier's Austin Representative

BOX 54 Texas Mutual Insurance Co

DWC Date Received

May 8, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
October 14, 2025	99212	$134.00	$0.00
	Total	$134.00	$0.00

Requester's Position

"This account was denied payment due to an authorization number being missing/invalid for the billed services. We believe this denial results in an inappropriate withholding of payment for the medically necessary services provided to your insured on this date and are appealing this decision."

Amount In Dispute: $134.00

Respondent's Position

"This claim is in the Texas Star Network network. Texas Mutual has reviewed the network provider directory for the provider's name and tax identification number and confirmed no record of CARDIO SPECIALISTS OF NORTH TX 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."

Response Submitted By: Texas Mutual Insurance Company

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 Chapter 1305 sets out the general provisions for workers' compensation health care networks.

Adjustment Reasons

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

1. 219 – Based on extent of injury.
2. 243 – Services not authorized by network/primary care providers.

Issues

1. What is DWC considering in this medical fee dispute?
2. Are the disputed services out-of-network health care?
3. Under what conditions is the insurance carrier liable for out-of-network healthcare?
4. Is the insurance carrier liable for the disputed services?

Findings

1. The requester is seeking reimbursement for evaluation and management services rendered on October 14, 2025. The insurance carrier denied payment stating, "services not authorized by network/primary care providers."
2. Per the submitted documentation and from information known to the division, the injured employee's claim is within the Texas Star Network healthcare certified network. The requester is not within the Texas Star network, as a result, the requester provided out-of-network health care to the injured employee.
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 Section 133.307. The requirements mentioned in the relevant sections of the TIC, Chapter 1305, are applicable to the 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 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."

4. The requester therefore has the burden to prove that the condition(s) outlined in the TIC Section 1305.006 were met for the insurance carrier to be liable for the disputed services. The requester has submitted insufficient documentation to prove that any of the conditions outlined in TIC Section 1305.006 applied to the disputed services.

   DWC concludes that the requester failed to demonstrate that any of the conditions of TIC Section 1305.006 were met in this dispute. As a result, DWC finds that the insurance carrier is not liable for the out-of-network care in dispute.

Conclusion

The outcome of this medical fee dispute is based on the evidence the 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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 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.