



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Voyage Medical Solutions, LLC

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-25-1077-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

January 23, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 8, 2024	L3670	\$647.04	\$0.00
July 8, 2024	E0676-NU	\$15,053.85	\$0.00
<b>Total</b>		<b>\$15,700.89</b>	<b>\$0.00</b>

### Requestor's Position

"Please review the attached Medical Fee Dispute Resolution Request and medical records for appeal."

**Amount in Dispute:** \$15,700.89

### Respondents' Position

"The DME items being billed were CPT E0676-NU for a total of \$15,053.85 and CPT L3670-LT for a total of \$647.04. No preauthorization was obtained for DME items over \$500 in accordance with rule 134.600(p)(9). Preauthorization #6475225 is on file for the surgery preformed [performed] and does not include the DME items prescribed by the surgeon. 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. Texas Insurance Code (TIC) [Chapter 1305](#) applies to health care certified networks.
4. [28 TAC §134.600](#) sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

### Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- CAC – 197 – Precertification/authorization/notification absent.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
- CAC – 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- DC4 – No additional reimbursement allowed after reconsideration.

### Issues

1. Is the requestor entitled to reimbursement for the dispute services?

### Findings

1. The requestor seeks reimbursement for durable medical equipment (DME), provided July 8, 2024. The insurance carrier denied the DME due to the absence of preauthorization. A review of the submitted documentation finds the following:

28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

28 TAC §134.203(b)(1) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers’ compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

The following describes the durable medical equipment (DME) in dispute:

- HCPCs code L3670 described as, “Shoulder orthosis (SO), acromio/ clavicular (canvas and webbing type), prefabricated, off-the-shelf.”
- HCPCs code E0676-NU – “Intermittent limb compression device (includes all accessories), not otherwise specified.”

28 TAC §134.600 states, “(p) non-emergency health care requiring preauthorization includes... (9) all durable medical equipment (DME) in excess of \$500 **billed charges per item** (either purchase or expected cumulative rental)”

The division finds that the DME in dispute required preauthorization pursuant to 28 TAC §134.600 (p)(9), the requestor did not obtain preauthorization, as a result reimbursement is not recommended for HCPCs codes L3670, and E0767-NU.

The Division concludes that the requestor has not established that reimbursement is due.

Conclusion

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

The DWC finds the requestor has not established that reimbursement is due.

**Order**

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

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

June 20, 2025  
\_\_\_\_\_  
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](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, call CompConnection at 1-800-252-7031, option 3 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 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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).