



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Voyage Medical Solutions LLC

Respondent Name

Texas Mutual Insurance Co

MFDR Tracking Number

M4-25-1316-01

Carrier's Austin Representative

Box Number 54

DWC Date Received

February 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 18, 2024	L1833	\$2,499.00	\$0.00

Requestor's Position

Please review the attached medical documentation to verify the severity of the insured's injury and the operative report will show the procedure required to correct the injury."

Amount in Dispute: \$2,499.00

Respondent's Position

"This claim is in the WorkWell, TX network and the health care service(s) rendered require preauthorization per Rule 134.600. Texas Mutual has no record that the provider obtained preauthorization. Health care providers can refer to network preauthorization requirements at texasamutal.com/provider-preauth. Our position is that no payment is due."

Response Submitted by: Texas Mutual Insurance

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. [Texas Insurance Code \(TIC\) Chapter 1305](#) applies to health care certified networks.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

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.
- W3 – 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.
- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

Issues

1. Is the respondent's position supported?
2. Are the disputed services out-of-network health care?
3. Under what conditions is the insurance carrier liable for out-of-network health care?
4. Is the insurance carrier liable for the disputed services?

Findings

1. The respondent states in their position statement, "...the health care service(s) rendered require preauthorization per Rule 134.600." DWC Rule 134.600 (p)(9) states, "non-emergency health care requiring preauthorization includes: all durable medical equipment (DME) in excess of \$500 billed charge per item (either purchase or expected cumulative rental);" Review of the submitted medical bill indicates a billed charge of \$2,499.00. The billed DME would require prior authorization. Additionally, the respondent states, "This claim is in the WorkWell, TX network."

2. The requestor seeks reimbursement for code L1833 – “Knee orthosis, adjustable knee joints, positional orthosis, rigid support, prefabricated, off-the shelf.” The insurance carrier denied for no network prior authorization. Per the submitted documentation, the injured employee’s claim is within the WorkWell network. Insufficient evidence was found to support the health care provider within the WorkWell network. The DWC finds the disputed service is out-of-network health care.
3. The requestor submitted the dispute requesting reimbursement for disputed services as governed by the Texas Labor Code statutes and Texas Administrative Code rules, including 28 TAC §133.307. The requirements mentioned in the relevant sections of TIC, Chapter 1305, are applicable to the DWC’s ability to apply the TLC statutes and DWC rules for out-of-network health care. TIC §1305.153 (c) states 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 which addresses 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 requestor has the burden to prove that the conditions outlined in TIC §1305.006 were met for the insurance carrier to be liable for the disputed services.

DWC finds that the requestor failed to provide any documentation to support that any of the conditions of TIC §1305.006 were met in this dispute. As a result, DWC finds that the insurance carrier is not liable for the out-of-network health care in dispute.

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

March 17, 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. 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 1-800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.