TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Methodist Dallas Medical Center Main

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-26-0085-01

Carrier's Austin Representative
Box Number 60

DWC Date Received
September 9, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 18 – 30, 2024	Occupational Therapy	$291.09	$0.00

Requester Position

"Requesting review of auth denial. Auth Referral #4101995 was supposed to cover 2 visits."

Amount in Dispute: $291.09

Respondent's Position

"This letter acknowledges receipt of your Liberty Health Care Network (HCN) complain on 9/11/2025."

Supplemental response submitted September 17, 2025

"We have again reviewed services from October 18, 2024 thru October 30, 2024 and the denial for 97760 and L3913 stands as Pre-Authorization was not requested for this code per Texas Administrative Code Rule 134.600."

Response submitted by: Liberty Mutual

Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.600 sets out the requirements of prior authorization.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- 4271 – Per TX Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- 5917 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requester is seeking reimbursement of code 97760-GO (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotics(s) encounter, each 15 minutes, for date of service October 18, 2024 and L3913 – Hand-finger orthosis (HFO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment for date of service October 30, 2024. The insurance carrier denied the medical bill initially as not submitted timely. Upon reconsideration, the claim was denied for lack of prior authorization.

   DWC Rule 134.600 (p)(5)(9)states, non-emergency health care requiring preauthorization includes: physical and occupational therapy services, all durable medical equipment (DME) in excess of $500 billed charges per item.

   Review of the submitted information submitted with the request for MFDR did not contain evidence to support the requester's reference to authorization number 4101995 for the disputed items. As prior authorization was required, the insurance carrier's denial is supported, no payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester and the respondent 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 §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 30, 2025
Signature	Medical Fee Dispute Resolution Officer	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 3 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 3 o correo electronico CompConnection@tdi.texas.gov.