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

General Information

Requestor Name
Memorial MRI & Diagnostics

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-25-1640-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 24, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 25, 2024	72141 MRI	$2,756.00	$370.08

Requestor's Position

"I received a denial for d/s 04/25/2024. This bill was rejected due to based on extent of injury."

Amount in Dispute: $2,756.00

Respondents' Position

"We are standing on the previous denial as denied for unrelated reasons therefore the bill was issued to the incorrect venue."

Response Submitted by: Enlyte on behalf of TASB Risk Management Fund

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 Texas Administrative Code (TAC) §133.305 sets out the general procedures for medical dispute resolution.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §134.203 sets out the fee guideline for professional medical services.

Denial Reasons

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

- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- XDI, 219, 751 - Based on the extent of injury.
- 29 - The time limit for filing has expired.
- 350 - Bill has been identified as a request for reconsideration or appeal.
- 351 - No additional reimbursement allowed after review of appeal/reconsideration.
- 95 - Plan procedures not followed.
- CTR – Re-eval filing limit expired. Re-eval line allowance remains the same.
- G15 - Pricing is calculated based on the medical professional fee schedule value.
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- U00 - There was no UR procedure/treatment request received.
- W3 - In accordance with TDI-DWC RULE 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did the insurance carrier submit a copy of a PLN in support of the denial reason?

2. Is the requester entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for radiology services provided on April 25, 2024. The service in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue.

   28 TAC §133.305(b) states that if a dispute over the extent of a covered work injury exists for the same service for which there is a medical fee dispute, the dispute regarding the extent of injury shall be resolved prior to the submission of a medical fee dispute.

   A review of the submitted documentation finds that the insurance carrier did not provide documentation to the DWC to support that it filed a Plain Language Notice (PLN) regarding the disputed conditions as required by §133.307(d)(2)(H). The respondent did not submit information to MFDR, sufficient to support that the PLN had ever been presented to the requestor or that the requestor had otherwise been informed of PLN prior to the date that the request for medical fee dispute resolution was filed with the DWC.

   The division finds that because the service in dispute does not contain an unresolved extent of injury issue, this matter is eligible for adjudication pursuant to the applicable rules and guidelines.

2. The requestor seeks payment for radiology service provided on April 25, 2024. 28 TAC §134.203 applies to the adjudication of radiology services. A review of the submitted documentation finds that on April 25, 2024, the requestor billed CPT code 72141, in the amount of $2,756.00 for an MRI. The insurance carrier denied the disputed charge indicating that there was no UR procedure/treatment requested received.

   The description of the radiology service billed under CPT code 72141 is, "an MRI of the lower back (lumbar spine) without contrast."

   28 TAC 134.600(p)(8) which states, "unless otherwise specified in this subsection, a repeat individual diagnostic study; (A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or (B) without a reimbursement rate established in the current Medical Fee Guideline…"

   To determine if preauthorization was required for the diagnostic study the division needs to determine if the individual diagnostic study is a repeat, and whether the reimbursement rate is greater than $350.00.

   A review of the submitted documentation finds that the insurance carrier did not submit documentation to support that the radiology service billed under CPT code 72141 was a repeat diagnostic study. As a result, the first threshold was not supported. Next the division will determine what the reimbursement rate is for CPT code 72141.

   28 TAC 134.203(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2024 DWC conversion factor for this service is 67.81.

The 2024B Medicare Conversion Factor is 33.2875.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77706, which is in Beaumont, Texas.

The Medicare participating amount will be based on the reimbursement for “Beaumont.”

The Medicare participating amount is $181.67. Using the above formula, the Division finds the MAR for CPT Code 72141 is $370.08.

The division finds that preauthorization was not required for the MRI in dispute. As a result, the requester is entitled to reimbursement for CPT Code 72141 in the amount of $370.08.

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.

DWC finds the requester is entitled to reimbursement in the amount of $370.08

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent must remit to the requestor $370.08 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 23, 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, 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.