



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requester Name**

Memorial MRI & Diagnostic

**Respondent Name**

Zurich American Insurance Company

**MFDR Tracking Number**

M4-26-0636-01

**Insurance Carrier's Austin Representative**

BOX 19 Flahive Ogden & Latson

**DWC Date Received**

November 4, 2025

### Summary of Findings

| Date(s) of Service | Disputed Services | Amount in Dispute | Amount Due |
|--------------------|-------------------|-------------------|------------|
| August 27, 2025    | 72141             | \$2,756.00        | \$411.97   |
| <b>Total</b>       |                   | \$2,756.00        | \$411.97   |

### Requester's Position

"I received a denial for d/s 08/27/2025. This bill was rejected due to service submitted unrelated to claimants injury. On 08/19/25 adjuster... via email stated compensability was: Per DO from the state injury extent is... Peer review also attached. Thank you for your prompt attention this matter."

**Amount In Dispute:** \$2,756.00

### Respondent's Position

The Austin carrier representative for Zurich American Insurance Co is Flahive Ogden & Latson. The respondent was notified of this medical fee dispute on November 6, 2025. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

**Response Submitted By:** Flahive, Ogden & Latson

## 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. Texas Administrative Code Section [133.305](#) sets out the procedures for resolving medical disputes.
2. 28 TAC Section [133.307](#) sets out the procedures for resolving medical fee disputes.
3. 28 TAC Section [134.203](#) sets out the fee guidelines for professional medical services.

### Adjustment Reasons

The insurance carrier denied payment with the following claim adjustment reasons:

- 5292 – Treatment/services submitted is unrelated to claimants injury.
- TXW3 – Bill is a reconsideration or appeal.
- TX193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

### Issues

1. What is DWC considering in this medical fee dispute?
2. Is the workers' compensation insurance carrier's denial based on the extent of injury supported by the evidence?
3. Is the requester entitled to reimbursement for the service in dispute?

### Findings

1. The requester seeks reimbursement in the amount of \$2,756.00 for an MRI rendered on August 27, 2025. The insurance carrier denied the disputed services due to an extent of injury issue. The division will review the documentation and determine whether the extent of injury issue is supported by the evidence.
2. According to 28 TAC Section [133.305\(b\)](#), if a dispute over the extent of injury exists for the same service involved in a medical fee dispute, that issue must be resolved before the fee dispute can be addressed. Additionally, 28 TAC Section [133.307\(d\)\(2\)\(H\)](#) requires the insurance carrier to provide evidence that a Plain Language Notice (PLN) regarding the

disputed injury conditions was filed and sent to the requester, or that the requester had actual notice of the PLN prior to submitting the fee dispute.

A review of the documentation finds that the respondent failed to provide sufficient evidence demonstrating that a PLN was filed or communicated to the requester. There is also no documentation establishing that the requester had prior notice of the PLN. Accordingly, the documentation does not support the existence of an unresolved extent of injury issue for the service in question. Therefore, the dispute is eligible for resolution under the applicable rules and guidelines.

3. The requester is seeking reimbursement in the amount of \$2,756.00 for an MRI provided on August 27, 2025. Because the insurance carrier's denial reason is not supported, the requester is entitled to reimbursement. To determine reimbursement for the MRI the division applies 28 TAC Section [134.203](#).

28 TAC Section [134.203](#) (b)(1) requires participants in the Texas workers' compensation system to apply Medicare payment policies for coding, billing, reporting, and reimbursement of professional medical services. This includes the application of coding guidelines, correct coding initiatives (CCI) edits, modifiers, and adjustments for health professional shortage areas and physician scarcity areas in effect on the date of service.

Specifically, 28 TAC Section [134.203](#) requires participants to apply the Medicare payment policies with minimal modifications, to determine the Maximum Allowable Reimbursement (MAR) for professional services.

Conversion factors for various service categories and settings (e.g., Evaluation & Management, Surgery in office or facility settings) are established for each calendar year and adjusted annually using the Medicare Economic Index (MEI).

The MAR is calculated as follows:

$$\text{MAR} = (\text{DWC Conversion Factor} \div \text{Medicare Conversion Factor}) \times \text{Medicare Payment}$$

- Service date: August 27, 2025
- The 2025 DWC Conversion Factor is 70.18
- The 2025 Medicare Conversion Factor is 32.3465
- Per the medical bills, the services were rendered in zip code 77055; "Houston"
- The Medicare Participating amount for CPT code 72141 at this locality is \$189.88.
- Using the above formula, the DWC finds the MAR is \$411.97.
- The respondent paid \$0.00.

Reimbursement of \$411.97 is recommended.

## Conclusion

The outcome of this medical fee dispute is based on the evidence 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 established that reimbursement is due.

## **Order**

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to reimbursement for the disputed services. It is ordered that respondent must remit to requester \$411.97 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

## **Authorized Signature**

\_\_\_\_\_  
Signature

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

February 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](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, please call CompConnection at 800-252-7031, option three 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 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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).