



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Memorial MRI & Diagnostic

Respondent Name

Poly America Inc

MFDR Tracking Number

M4-26-0997-01

Insurance Carrier's Austin Representative

BOX 10 Tom Lang - Sedgwick

DWC Date Received

December 4, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
July 15, 2025	73721	\$2,756.00	\$437.01
Total		\$2,756.00	\$437.01

Requester's Position

"I received denials for D/S 07/15/2025 for 73721 MRI left knee. This bill was denied due to not being medically necessary. We received authorization [redacted] from adjuster... and proceeded with the referral from Dr Aaron Eubanks."

Amount In Dispute: \$2,756.00

Respondent's Position

"As there was a CCH Decision and Order that found the compensable injury of [redacted], does not extend to or include a [injuries], the carrier is not liable for the requested medical treatment for an MRI under DWC Rule 134.600.

Poly-America, LP and Gallagher Bassett Services, Inc. request the MR be dismissed as the MRI was requested for non-compensable diagnoses."

Response Submitted By: Ricky D. Green, PLLC

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. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC Section 134.203](#) sets out the fee guideline for professional medical services.
3. [28 TAC Section 134.600](#) sets out the Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.

Adjustment Reasons

1. 00663 – Reimbursement has been calculated based on the state guidelines.
2. 50-3 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
3. P12 – Workers' Compensation jurisdictional fee schedule adjustment.
4. 93 – No claim level adjustments.
5. 18-3 – Exact duplicate claim/service.

Issues

1. What is DWC considering in this medical fee dispute?
2. Are the insurance carrier's denial reasons supported?
3. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement for an MRI performed on July 15, 2025, billed under CPT code 73721, in the amount of \$2,756.00. The insurance carrier denied payment on the basis that the service was non-covered because it was not deemed medically necessary.
2. In its response, the insurance carrier states, in pertinent part: *"As there was a CCH Decision and Order that found the compensable injury of [redacted] does not extend to or include [injuries], the carrier is not liable for the requested medical treatment."*

Pursuant to 28 TAC Section 133.307(d)(2)(F), responses to a request for Medical Fee Dispute Resolution (MFDR) must address only those denial reasons previously presented to the requester prior to the filing of the MFDR request. Any new denial reasons or defenses raised during the MFDR process will not be considered. Additionally, if the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR must be dismissed in accordance with subsection (f)(3)(B) or (C).

Pursuant to 28 TAC Section 133.307(d)(2)(H), if a medical fee dispute involves issues of compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice (PLN) issued in accordance with 28 TAC Section 124.2.

Further, pursuant to 28 TAC Section 133.307(d)(2)(I), if the dispute involves medical necessity, the insurance carrier must attach documentation supporting an adverse determination in compliance with 28 TAC Section 19.2005 regarding utilization review standards.

A review of the submitted documentation indicates that the insurance carrier did not include a copy of a PLN with its response. Additionally, the medical necessity denial asserted during the bill review process is unsupported, as the requester obtained preauthorization for the MRI at issue.

Under 28 TAC Section 134.600(c)(1)(B), an insurance carrier is liable for all reasonable and necessary medical costs when preauthorization for the health care service listed in subsection (p) has been approved prior to the delivery of care. Because the carrier's denial reasons are not supported by the required documentation, the dispute is reviewed pursuant to the applicable rules and guidelines.

3. The requester billed for an MRI performed on July 15, 2025. As the insurance carrier's denial reasons are not supported, the requester is entitled to reimbursement.

Reimbursement for this service is governed by 28 TAC Section 134.203. Section 134.203(a)(5) defines Medicare payment policies as those methodologies and payment rules established by the Centers for Medicare and Medicaid Services (CMS). Pursuant to 28 TAC Section 134.203(c)(1), the Maximum Allowable Reimbursement (MAR) for professional services is determined by applying Medicare payment policies with minimal modifications. For radiology services performed in an office setting, the applicable conversion factor is \$53.68.

The MAR is calculated using the following formula:

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

- Date of service: July 15, 2025
- 2025 DWC Conversion Factor: 70.18
- 2025 Medicare Conversion Factor: 32.3465
- Service locality: ZIP code 75230 (Medicare locality "04412 11, Dallas")
- Medicare Participating amount for CPT 73721: \$201.42

Applying the formula, the MAR is \$437.01. The requester seeks \$2,756.00, and the respondent paid \$0.00. Therefore, reimbursement in the amount of \$437.01 is recommended.

Accordingly, the DWC finds that the requester is entitled to reimbursement for the disputed

service, and \$437.01 is due.

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 \$437.01 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

_____	_____	February 12, 2026
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 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. 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.

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.