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
Memorial MRI & Diagnostic, LLC

Respondent Name
City of Dallas

MFDR Tracking Number
M4-26-1019-01

Insurance Carrier's Austin Representative
BOX 53 Hoffman Kelley LLP

DWC Date Received
December 8, 2025

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
May 13, 2025	72141	$2,756.00	$409.50
May 13, 2025	72331 [73221]	$2,756.00	$437.72
	Total	$5,512.00	$847.22

Requester's Position

"I received denials for D/S 05/13/2025 for 73221 MRI right shoulder and 72141 MRI cervical. This bill was denied due to pre-cert/auth not present. We received authorization 107738 from adjuster... and proceeded with the referral from Dr. Stephen Wicker. Please review documentation and reconsider payment".

Amount In Dispute: $5,512.00

Respondent's Position

"We acknowledge receipt of the Medical Dispute Resolution concerning claimant... from Memorial MRI & Diagnostic for the date of service May 13, 2025. Our records indicate that no preauthorization was obtained for the MRI before the performance of these services. Furthermore, the

preauthorization number 107738 referenced in this correspondence is not present in the preauthorization history for the injured employee. For this reason, payment will not be recommended".

Response Submitted By: IMO

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 134.600 covers requirements for preauthorization, concurrent utilization review, and voluntary health care certification.
3. 28 TAC Section 134.203 provides the fee guidelines for professional medical services.

Adjustment Reasons

1. 197 – Precertification/authorization/notification/pre-treatment absent.
2. 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
3. W3 – TDI Level 1 appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to reimbursement for the radiology services in dispute?

Findings

1. The requester seeks reimbursement totaling $5,512.00 for two radiology services billed under CPT codes 73221 and 72141, performed on May 13, 2025. The services were denied by the insurance carrier citing precertification/authorization/notification/pre-treatment absent. The insurance carrier did not submit a response to the medical fee dispute resolution request. Therefore, the determination is based solely on the documentation provided by the requester. A review of the submitted records does not support that the disputed services qualify as repeat individual diagnostic studies.

2. Under 28 Texas Administrative Code (TAC) Section 134.600(p)(8), reimbursement limitations apply to repeat individual diagnostic studies that either:

   (A) have a reimbursement rate greater than $350.00 as established in the current Medical Fee Guideline, or

   (B) do not have an established reimbursement rate in the current Medical Fee Guideline.

   To determine whether the disputed charges exceed the $350.00 threshold under the Medical Fee Guideline, the Division of Workers' Compensation (DWC) calculated the reimbursement for each disputed CPT code.

   Pursuant to 28 TAC Section 134.203, radiology services are reimbursed using Medicare payment policies with minimal modifications. Specifically, 28 TAC Section 134.203(c)(1) provides that the maximum allowable reimbursement (MAR) for professional services is calculated by applying the DWC conversion factor to the Medicare payment amount. For services performed in an office setting, the DWC conversion factor is $52.83.

   The formula used is:
   (DWC Conversion Factor ÷ Medicare Conversion Factor) × Medicare Payment = MAR

   Service Details:

   - Date of Service: May 13, 2025
   - Service Location: ZIP Code 75137 (Dallas, Locality 11)
   - Carrier: 4412

   CPT Code 73221

   - Participating Provider Rate: $201.75
   - MAR: $437.72
   - Amount Billed: $2,756.00
   - Amount Paid: $0.00
   - Amount Sought: $2,756.00
   - Amount Recommended: $437.72

   CPT Code 72141

   - Participating Provider Rate: $188.74
   - MAR: $409.50
   - Amount Billed: $2,756.00
   - Amount Paid: $0.00
   - Amount Sought: $2,756.00
   - Amount Recommended: $409.50

Based on the calculations above, the DWC determines that the requesters denial due to lack of preauthorization is not supported. The requester is therefore entitled to a total reimbursement of $847.22 for the radiology charges rendered on May 13, 2025.

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 $847.22 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 12, 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. 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 electronico CompConnection@tdi.texas.gov.