TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BART BUTLER KEY, DC

Respondent Name
METROPOLITAN TRANSIT AUTHORITY HARRIS COUNTY

MFDR Tracking Number
M4-17-2288-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 30, 2017

Response Submitted by:
Flahive, Ogden & Latson

REQUESTOR'S POSITION SUMMARY

"Preauthorization was not required as the patient had a previous right knee MRI on 6/22/16 but never had a prior left knee MRI. Therefore rule 134.6; P (8) for Non-emergency healthcare requiring preauthorization for a repeat diagnostic study would not apply. I assume the carrier's audit is unable to recognize the fact the previous study was performed on the opposite knee and is improperly denying this as a repeat study. Any preauthorization denials would not be applicable as they were not required for these services as long as they were reasonable and necessary. Per rule 134.6 these services were reasonable and necessary in accordance with ODG as the patient had failed conservative treatment and had ample healing time since the date of his injury."

RESPONDENT'S POSITION SUMMARY

"Dr. Key, as the referral doctor, maintains the position that the MRI is within the ODG and did not require pre-authorization. This is against the great weight of the medical evidence since the treating doctor of record himself, Dr. Barnett, requested pre-authorization for the MRI. In addition, two separate medical reviewers opined that it was outside the guidelines, one upon reviewing the initial request and a second with the reconsideration. The medical evidence does not support Dr. Key's contention that the first-time diagnostic did not require pre-authorization."

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
October 22, 2016	73721-TC	$2,200.00	$269.16

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.

3. 28 TAC §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 39 - Services were denied at the time of pre-authorization.

Issue(s)

1. Is the insurance carrier's denial reason supported?
2. What is the definition of modifier "TC"?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for disputed services 73721-TC rendered on October 22, 2016. The insurance carrier denied/reduced the disputed service(s) with denial reduction code(s), "39 - Services were denied at the time of pre-authorization."

   28 TAC §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (8) 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."

   He requestor states in pertinent part, "Preauthorization was not required as the patient had a previous right knee MRI on 6/22/16 but never had a prior left knee MRI ."

   The respondent states in pertinent part, "The medical evidence does not support Dr. Key's contention that the first-time diagnostic did not require pre-authorization."

   The DWC finds that the respondent submitted insufficient documentation to support that the diagnostic study was a repeat, and that the reimbursement rate is greater than $350.00. As a result, the DWC finds that the denial reason for non-payment is not supported. The requestor is therefore entitled to reimbursement for the service in dispute, pursuant to 28 TAC §134.203.

2. 28 TAC §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor appended modifier "TC" to the radiology service rendered on October 22, 2016. Modifier "TC" is defined as "Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles."

3. 28 TAC §134.203 states in pertinent part, "(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..."

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

   The 2016 DWC conversion factor for this service is 56.82.

   The Medicare Conversion Factor is 35.8043.

The services were rendered in zip code 77028, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston."

The Medicare Participating Amount for Professional Component is $169.61. Using the above formula, the Division finds the MAR is $269.16. The respondent paid $0.00. The requestor is due the difference between the MAR and amount paid is $269.16.

4. Review of the submitted documentation finds that the requestor is therefore entitled to reimbursement in the amount of $269.16.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $269.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of TLC Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to reimbursement for the service involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $269.16 plus applicable accrued interest per 28 TAC §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		May 6, 2021
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 in accordance with 28 TAC §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** form **DWC045M** in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.