MEDICAL CONTESTED CASE HEARING NO. 10017
M4-09-7448-01

## DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

## ISSUES

A contested case hearing was held on August 18, 2009 to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the Medical Fee Dispute Resolution Findings and Decision (MFDRFD) that Petitioner, Dr. R - Complete Medical Care, is not entitled to reimbursement of a total of $103.89 under CPT code 73220-RT-26 for services rendered to the Claimant on January 7, 2009?

## PARTIES PRESENT

Petitioner/Provider appeared and was represented by Dr. R. Respondent/Carrier appeared and was represented by DH, attorney. The Claimant did not appear and his appearance was waived by the parties.

## BACKGROUND INFORMATION

On January 7, 2009, Dr. R, an orthopedic surgeon, conducted a follow-up examination of the Claimant relative to his compensable _____ injury. Prior to this visit, the Claimant had undergone a repeat right ankle and foot MRI on January 5, 2009, and the January 7, 2009 visit with Dr. R was, at least in part, for the purpose of reviewing the MRI results. In connection with this visit, Dr. R thereafter sought reimbursement for CPT code 73220RT with a 26 modifier. The Carrier initially denied reimbursement using denial code 16 - "Claim/service lacks information which is needed for adjudication." *See, e.g., Hearing Officer Exhibit No. 1.* The Carrier also noted that the complete MRI report needed to be submitted. Upon reconsideration, the Carrier denied reimbursement for several reasons: 1) denial code 16; 2) denial code 148 - "This procedure on this date was previously reviewed."; 3) denial code 18 - "Duplicate claim/service"; 4) denial code 193 - "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly."; and 5) denial code NFR - "This bill indicates IMO Nurse Fee Review." *See Hearing Officer Exhibit No. 1.* The Medical Fee Dispute Resolution (MFDR) Officer explained the following in determining that Dr. R is not entitled for any reimbursement in connection with this CPT code with modifier 26:

> When billed with a CPT code, the appendage of the 26 modifier indicates the 'interpretation of a diagnostic procedure'. A review of the medical record submitted states that the 'patient's MRI was available for review'. A 'review' of films does not constitute the billing of the 26 modifier. There was no report submitted signed by Dr. R identifying the 'reading/interpreting' of this film. In accordance with Rule 134.203 (b), being that this film was only reviewed, and not 'interpreted',

payment can not be recommended. Additionally, code 73220 is for an MRI to the 'upper extremity' and the medical report submitted identifies that this MRI review was for the 'lower extremity'/ankle.

*See Hearing Officer Exhibit No. 1.* It should be noted here that the documentation submitted to the MFDR Officer indicated that the amount in dispute for the service in question was $146.97. At this contested case hearing, Dr. R represented that the amount in dispute is only $103.89.

Petitioner's/Dr. R's position at the hearing was that Medicare reimbursement policies control the question of whether a physician can bill for radiographic readings in connection with the professional component for providing that service, not the interpretations of such policies by entities like _____, which is a Medicare carrier, and upon whose interpretations the Carrier bases its position. Dr. R asserted that under Medicare policies, he is entitled to be reimbursed using a 26 modifier, regardless of whether it is the first or second reading of the radiographic study, and regardless of whether his interpretation of the study was substantially different from the initial reading by a radiologist. Dr. R's position is that to be reimbursed under a 26 modifier, he need not generate a separate report containing his interpretation of the diagnostic study, aside from his report of his examination of the patient. Dr. R also presented evidence showing that he has always been reimbursed by Carriers in other cases, including the Carrier herein, using a 26 modifier, and that such should also be approved in this case. Dr. R testified that the Carrier has previously provided reimbursement in this case under a CPT code that included a 26 modifier. Lastly, Dr. R admitted into evidence other MFDRFD's issued by the Division in other cases that determined that he was entitled to reimbursement under CPT codes that appended a 26 modifier.

Respondent's/Carrier's position was that under Medicare policy, a physician can bill for radiographic readings, but he can only bill using a 26 modifier for a second reading of a test if his interpretation of the test is substantially different from the initial (radiologist's) reading of the test, and if he generates a complete written report regarding his interpretation of the test, similar to that which would be done by the specialist (*e.g.*, a radiologist). The Carrier argued that a physician's mere review of a study, which results in an interpretation that is the same as or similar to the initial (radiologist's) interpretation of the study, is included in the payment for the office visit/examination and cannot be billed using a 26 modifier, otherwise the Carrier is paying multiple times for the same service.

Division Rule 134.203 (b) provides in pertinent part:

> (b) 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. ...

Both the Petitioner and the Respondent rely upon Section 20.1 in Chapter 13 of the Medicare Claims Processing Manual, which states as follows:

> 20.1 - Professional Component (PC)

(Rev. 1, 10-01-03)

> Carriers must pay for the PC of radiology services furnished by a physician to an individual patient in all settings under the fee schedule for physician services regardless of the specialty of the physician who performs the service. For services furnished to hospital patients, carriers pay only if the services meet the conditions for fee schedule payment and are identifiable direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of therapeutic procedures. The interpretation of a diagnostic procedure includes a written report.

The Respondent also relies upon publications by TrailBlazer Health Enterprises, LLC and the American Academy of Orthopaedic Surgeons (AAOS), which note a distinction between a doctor's review of a study versus his interpretation of a study, and state that a separate report containing the doctor's findings relative to his interpretation of the study is required to be reimbursed using a 26 modifier.

While Dr. R's testimony was very credible and helpful, a review of his January 7, 2009 report contains only the following with respect to the January 5, 2009 right ankle and foot MRI: "He underwent a repeat right ankle and foot MRI and is here to review the results. ... The MRI indicates that he does not have a PT tendon tear." *Hearing Officer Exhibit No. 1.* Given the Medicare payment policy that for reimbursement for the professional component of radiology services, the interpretation of a diagnostic procedure includes a written report, the MFDRFD correctly concludes that Dr. R is not entitled to any reimbursement under CPT code 73220-RT-26. Dr. R's January 7, 2009 report does not contain an interpretation of the January 5, 2009 MRI.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

## FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On _____, Claimant was the employee of the (Self-Insured), Employer.

   C. On _____, Employer had workers' compensation insurance coverage through self-insurance.

   D. On _____, Claimant sustained a compensable injury while in the course and scope of his employment with the (Self-Insured).

   E. The MFDR Officer determined herein that Dr. R is entitled to no reimbursement for CPT code 73220-RT-26 for services rendered to the Claimant on January 7, 2009.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. Dr. R, Petitioner, is not entitled to any reimbursement under CPT code 73220-RT-26 for services rendered to the Claimant on January 7, 2009 because he failed to provide a separate report containing his findings relative to his interpretation of the study.

## CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is not contrary to the decision of the MFDRFD dated May 26, 2009 herein that Dr. R, Petitioner, is not entitled to any reimbursement under CPT code 73220-RT-26 for services rendered to the Claimant on January 7, 2009.

## DECISION

Dr. R, Petitioner, is not entitled to reimbursement of a total of $103.89 under CPT code 73220-RT-26 for services rendered to the Claimant on January 7, 2009.

## ORDER

Carrier is not liable for the benefits at issue in this hearing. The Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021.

The true corporate name of the Self-Insured is **(SELF-INSURED)**, and the name and address of its registered agent for service of process is:

**CITY SECRETARY - AR**
**(STREET ADDRESS)**
**(CITY), TX (ZIP CODE)**

Signed this 28th day of August, 2009.

Patrice Fleming-Squirewell
Hearing Officer