Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MILLENIUM CHIROPRACTIC

Respondent Name
MARKEL INSURANCE CO

MFDR Tracking Number
M4-14-2456-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
APRIL 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier's denial for the Chiropractic Manipulative Treatment (98941) rendered on the dates listed above based on **denial code (852-106)** also listed above is invalid. According to the TDI Advisory 96-17 (enclosed), '*for the purposes of preauthorization under Rule §134.600, manipulations are NOT considered a part of physical or occupational therapy.' The TDI Advisory goes on to say, 'insurance carriers shall not deny payment for therapeutic or osteopathic manipulations due to preauthorization not being obtained*'."

Amount in Dispute: $2,346.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The majority of the medical bills in dispute were denied based on the fact that the procedure code billed was not appropriate for the number of body areas indicated by the diagnoses. On each medical bill, the only diagnoses listed were 847.2 and 724.2, both of which refer to the lumbar spine area only. In the 2013 AMA CPT Professional Edition, in regard to chiropractic manipulations, it states: for the purposes of CMT, the five spinal regions referred to are: cervical region, thoracic region, lumbar region, sacral region, and pelvic region. There are different CPT codes to be utilized based on the number of spinal regions manipulated. Requestor in the case used 98941 which if for 3-4 regions of spinal manipulations. This is in direct conflict with the diagnoses listed. Requestor only treated spinal region area on each date of service in order to gain a higher reimbursement. Requestor should have used CPT code 98940 for 1-2 regions. Therefore, no reimbursement is owed as the Requestor did not perform the treatment he billed."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2013 through October 24, 2013	CPT Code 98941 (X34 Dates) Chiropractic manipulative treatment (CMT); spinal, 3-4 regions	$69.00 X 34 = $2,346.00	$1,226.40

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 effective July 1, 2012 sets out the procedures for health care providers to obtain preauthorization for specific healthcare services.
3. 28 Texas Administrative Code § 137.100 effective January 18, 2007, sets out the treatment guidelines.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 852-106 – Per Carrier pre-authorization not requested $0.00 denied.
   - 388 – The procedure code(s) billed are not appropriate for the number of body areas indicated by the diagnoses.
   - 663-Reimbursement has been calculated according to the state fee schedule guidelines.
   - 648-099-Texas bill reconsideration.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Does the documentation support billing of CPT code 98941?
3. Is the requestor due reimbursement?

Findings

1. According to the submitted explanations of benefits, the insurance carrier reduced or denied reimbursement for CPT code 98941 with reason code "852-106"on July 17, July 18, July 22, July 24, July 25, July 29, July 31, August 1, August 26, August 28, September 16, September 23, September 25, October 3, October 10, October 14, October 16, October 21, October 23, and October 24, 2013.

   28 Texas Administrative Code §134.600(p)(12) , the non-emergency health care treatment that requires preauthorization include "treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);."

   28 Texas Administrative Code § 137.100(e), states "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   The requestor billed CPT code 98941 for the diagnoses 847.2 – Lumbar sprain and strain, and 724.2-Lumbago.

   For the diagnoses 847.2 and 724.2, the Division refers to the Low Back Chapter of the Official Disability Guidelines (ODG), under the heading Manipulations in the Procedure Summary :

   ODG Chiropractic Guidelines:
   Therapeutic care –
   Mild: up to 6 visits over 2 weeks
   Severe:* Trial of 6 visits over 2 weeks
   Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity
   Elective/maintenance care – Not medically necessary
   Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care
   * Severe may include severe sprains/strains (Grade II-III[1]) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders

   The requestor noted on the July 17, 2013 medical record that this was the "1st Therapy Visit." Based upon the ODG Chiropractic Guidelines, for an acute low back sprain strain a total of up to 18 visits over 6-8 weeks are recommended if there is evidence of objective functional improvement. A review of the medical records finds

that the requestor performed 18 visits from July 17, 2013 through August 28, 2013. In addition, the ODG requires evidence of objective functional improvement. The requestor noted improvement in the claimant's pain scale from 7 to 5, and moderate muscle spasms to mild moderate muscle spasms from July 17, 2013 to August 28, 2013. Therefore, the Division finds that per the ODG, the 18 manipulations rendered from July 17, 2013 through August 28, 2013 did not require preauthorization.

The manipulations rendered on September 16, September 23, September 25, October 3, October 10, October 14, October 16, October 21, October 23, and October 24, 2013 required preauthorization per 28 Texas Administrative Code §134.600(p)(12). The requestor did not submit any documentation to support preauthorization had been obtained for these services; therefore, a preauthorization issue exists for these dates of service. As a result, reimbursement cannot be recommended.

2. According to the explanation of benefits, the respondent also denied reimbursement for CPT code 98941 based upon reason code "388" on the following dates: July 17, July 18, July 22, July 24, July 25, July 29, August 5, August 7, August 8, August 12, August 15, August 19, August 21, August 22, August 26, September 9, September 11, September 12, September 16, September 25, October 7, and October 9, 2013.

   CPT Code 98941 is defined as "Chiropractic manipulative treatment (CMT); spinal, 3-4 regions."

   - The five regions of the spine are: Cervical, Thoracic, Lumbar, Pelvic (Sacro-Illiac), and Sacral.
   - A review of the requestor's progress notes indicates that the requestor adjusted/manipulated the Thoracic, Lumbar and Sacrum on July 18, July 22, July 24, July 25, July 29, August 5, August 7, August 12, August 15, August 19, August 21, August 22, August 26, September 9, September 11, September 16, September 25, October 7, and October 9, 2013. The Division finds that the requestor supported billing of CPT code 98941 on these dates; therefore, the respondent's denial of payment based upon reason code "388" is not supported.
   - A review of the requestor's progress notes indicates that the requestor adjusted/manipulated the Lumbar and Sacrum on July 17, August 8, September 12, 2013; therefore, the requestor's documentation does not support billing CPT code 98941. As a result, the respondent's denial of payment based upon reason code "388" is supported. Therefore, reimbursement is not recommended for these dates.

3. As discussed above, the twenty-one dates of service eligible for reimbursement are July 18, July 22, July 24, July 25, July 29, July 31, August 1, August 5, August 7, August 12, August 15, August 19, August 21, August 22, August 26, August 28, September 9, September 11, September 16, October 7 and October 9, 2013.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   - To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).
   - The 2013 DWC conversion factor for this service is 55.3.
   - The Medicare Conversion Factor is 34.023
   - Review of Box 32 on the CMS-1500 the services were rendered in zip code 75061 in Irving, Texas. Per Medicare the provider is reimbursed using the locality of Dallas, Texas.
   - The Medicare participating amount for code 98941 is $35.93.
   - Using the above formula the MAR is $58.40/day. This amount multiplied by 21days equals $1,226.40. The respondent paid $0.00; therefore, the requestor is due $1,226.40.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,226.40.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,226.40 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Elizabeth Pickle, RHIA	05/28/2014
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 Texas Administrative Code §133.307, effective May 31, 2012, *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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR 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 Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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

.