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
MILLENNIUM CHIROPRACTIC

Respondent Name
GREAT AMERICAN ALLIANCE INSURANCE CO

MFDR Tracking Number
M4-19-4426-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 7, 2019

Response submitted by:
The Silvera Law Firm

REQUESTOR'S POSITION SUMMARY

"These are PRE-AUTHORIZED services, approved by the insurance carrier and according the ODG guidelines, and MUST BE PAID…The relatedness of my treatment of this patient's compensable condition is absolutely certain. If the carrier wishes to make the argument that my treatment is NOT related, THE CARRIER MUST PROVIDE A PLN-11…NO SUCH PLN-11 DENYING THE LATERAL MENISCUS TEAR OF THE LEFT KNEE, OR ANY OTHER CONDITION IN THE LEFT KNEE, WAS EVER RECEIVED BY THIS CLINIC WITHIN 45 DAYS OF ANY OF THE UNPAID DATES OF SERVICE."

RESPONDENT'S POSITION SUMMARY

"The treatment was denied by bill review based upon the treatment not being related to the accepted compensable injury…Carrier has accepted a right knee lateral meniscus tear. On February 22, 2019, the administrative law judge issued a CCH decision and order finding that claimant's compensable injury of June 2, 2017, does **not** extend to or include a right knee medial meniscus tear, a recurrent RIGHT KNEE LATERAL MENISCUS TEAR AFTER October 6, 2017, right knee osteoarthritis, or right knee degenerative joint disease/chondromalacia."

Response Submitted By: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 29, 2018 thru July 30, 2018	Chronic Pain Management Program CPT Code 97799-CP (240 hours total) (33 dates of service)	$24,000.00	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305, effective March 30, 2014 sets out the general procedure for Dispute Resolution.
3. 28 Texas Administrative Code § 142.16, effective May 10, 2000, provides for the decision process in the Benefit Contested Case Hearing.
4. 28 Texas Administrative Code §133.240, effective March 30, 2014 provides for medical bill processing/audit by insurance carrier.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment reason codes:
   - 16-Claim/service lacks information or has submission/billing error(s).
   - 270-No allowance has been recommended for this procedure/service/supply.
   - 270-Denied. Treatment not related to accepted work injury. Treatment not medically necessary per peer review. Treatment not authorized.
   - 270-Denied. Treatment not related.
   - 160-Injury/illness was the result of an activity that is a benefit exclusion.
   - B79-Treatment is not related to the accepted injury and or diagnosis and is denied.
   - B79-Denied, treatment not related to accepted work injury.
   - P2-Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - 229-Procedure does not appear related to the injury and/or diagnosis. We will re-evaluate this charge upon receipt of clarifying information.

Issues

1. Was the chronic pain management program for treatment of the right knee or the left knee?
2. Are the denial reasons supported?

Findings

The requestor is seeking medical fee dispute resolution for chronic pain management program, procedure code 97799-CP, in the amount of $24,000.00.

1. The requestor asserts that the chronic pain management program was performed to treat the left knee; however, the medical billing and the medical documentation provided clearly indicate that the treatment was for the right knee. For example ICD-10 code S83.281D described as "Other tear of lateral meniscus current injury right knee subsequent encounter" is listed on the medical bills. Similarly, under the description of injury and past medical history both indicate that reported injury was to the right knee, and that there had been a surgery to the right knee.

   The DWC concludes that the services in dispute were provided to treat injuries to the right knee. The requestor's position that the disputed chronic pain management program was performed to treat the left knee is not supported.

2. The respondent issued explanations of benefits denying the chronic pain management program in dispute for "270-Denied. Treatment not related to Compensable injury. Not related per Judge Decision." In its response to the medical fee dispute, the respondent provided a copy of the refenced decision.

   As discussed above, the medical documentation indicates that the chronic pain management program was performed to treat a right knee lateral meniscus tear.

   The recurrent right knee lateral meniscus tear is not part of the compensable injury. Specifically, an order issued by the DWC hearings section on February 22, 2019 concluded that the compensable

injury of June 2, 2017 *did not extend* to recurrent right knee lateral meniscus tear after October 6, 2017. That decision was not appealed and is therefore final.

The DWC hearings section issued a final decision stating that the compensable injury **did not extend** to a recurrent right knee lateral meniscus tear after October 6, 2017. The service in dispute was provided to evaluate the non-compensable recurrent right knee lateral meniscus tear. The DWC concludes that the carrier's denials of payment is supported.

Conclusion

The services in dispute were provided for injuries that are not part of the compensable injury. As a result, no reimbursement is due

ORDER

Based upon the documentation submitted by the parties, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		09/06/2019
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this DWC decision. To appeal, submit DWC Form-045M titled ***Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)*** found at https://www.tdi.texas.gov/forms/form20numeric.html.

Follow the instructions on pages 3 and 4. The request must be received by the DWC within twenty days of your receipt of this decision. This decision becomes final if the request for review of this decision is not timely made.

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.

If you have questions about the DWC Form-045M, please call CompConnection at 1-800-252-7031, Option 3 or you may email your question to CompConnection@tdi.texas.gov