TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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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
M4-19-4427-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 7, 2019

Response submitted by:
The Silvera Law Firm

REQUESTOR'S POSITION SUMMARY

"In accordance with the 1996 Medical Fee Guideline, the carrier MUST pay us for a minimum of THREE FCEs. YOU HAVE PAID FOR ZERO. TIME TO PAY…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 degenerative joint disease/chondromalacia."

Response Submitted By: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 7, 2018	16 units 97750 FC	$873.76	$0.00
June 6, 2018	14 units 97750 FC	$764.54	$0.00
June 25, 2018	12 units 97750 FC	$655.32	$0.00
August 1, 2018	12 units 97750 FC	$655.32	$0.00
	TOTAL	$2,948.54	$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 Compensable injury. Not related per Judge Decision.

Issues

1. Was the right knee, or the left knee evaluated by the requestor?
2. Are the denial reasons supported?

Findings

The requestor is seeking medical fee dispute resolution for four functional capacity evaluations (FCEs), procedure code 97750-FC, in the amount of $2,948.54.

1. The requestor asserts that the FCEs were performed to evaluate the left knee; however, the medical billing and the medical documentation provided clearly indicate that the right knee was evaluated. For example, ICD-10 code S83.271D described as "Complex tear of lateral meniscus current injury right knee subsequent encounter" is listed on the medical bills for the first three FCEs, and ICD-10 code S83.281D described as "Other tear of lateral meniscus current injury right knee subsequent encounter" for the final FCE. 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 division concludes that the services in dispute were provided to evaluate injuries to the right knee. The requestor's position that the disputed FCEs were performed to evaluate the left knee is not supported.

2. The respondent issued explanations of benefits denying the FCEs 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 FCE were performed to evaluate 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 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 division 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 division has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

		08/29/2019
Signature	Medical Fee Dispute Resolution Officer	Date

RIGHT TO APPEAL

Either party to this medical fee dispute may seek review of this division 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 division 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 division using the contact information listed on the form or to the field office handling the claim.

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