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
DALLAS AREA RAPID TRANSIT

MFDR Tracking Number
M4-20-2427-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
JUNE 5, 2020

REQUESTOR'S POSITION SUMMARY

"These are PRE-AUTHORIZED services, approved by the insurance carrier in accordance with the ODG guidelines and must be paid."

Amount in Dispute: $26,521.28

RESPONDENT'S POSITION SUMMARY

"Please see the attached EOB and check information…we recommended payment as the original requests were processed by the previous vendor and we concluded these services should be paid."

Response Submitted By: CareWorks

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2019 Through September 9, 2019	CPT Code 97799-CP (239 hours) Chronic Pain Management Program	$23,900.00	$0.00
May 21, 2019 June 17, 2019 July 15, 2019	CPT Code 97750-FC Functional Capacity Evaluation (FCE)	$2,621.28	$0.00
TOTAL		$26,521.28	$0.00

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 (DWC)

Background

1. 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230, effective July 17, 2016 sets out the reimbursement guidelines for return to work rehabilitation programs.
3. 28 TAC §134.225, effective July 7, 2016, sets the reimbursement guidelines for FCEs.

4. The services in dispute were reduced or denied payment based upon claim adjustment reason code(s):
    - 219-Based on extent of injury.
    - TX07-Charge unrelated to the compensable injury.
    - P12-Workers' compensation state fee schedule adjustment.
    - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
    - 225-Penalty or interest payment by payer.
    - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - W3-Reporting purposes only.

Issues

Is the requestor entitled to reimbursement for chronic pain management program and FCE's rendered from May 21, 2019 through September 9, 2019?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $26,521.28 for chronic pain management program and FCE's rendered from May 21, 2019 through September 9, 2019.

2. The respondent initially denied reimbursement for the disputed chronic pain management program and FCEs based upon extent of injury. Upon receipt of this request for medical fee dispute resolution, the respondent did not maintain the denial and issued payment in full for the disputed services.

3. Millennium Chiropractic was notified by the Carrier and by the Division's medical fee dispute resolution program that the full amount in dispute was paid, however Millennium Chiropractic has not taken the opportunity to refute the carrier's evidence or respond to the Division with additional information.

   For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that Millennium Chiropractic has already been paid for the service in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/21/2020 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 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 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 DWC. **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.