



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

MILLENNIUM CHIROPRACTIC

**Respondent Name**

AMERICAN ZURICH INSURANCE COMPANY

**MFDR Tracking Number**

M4-22-1777-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 19, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 19, 2021 through June 9, 2021	97799-CP-GP	\$11,200.00	\$11,200.00
<b>Total</b>		\$11,200.00	\$11,200.00

### Requestor's Position

"The services rendered on the above dates of service were pre-authorized by the carrier (see enclosed pre-authorization letters) and were performed and billed in accordance with the ODG and the 1996 Medical Fee Guideline and MUST BE PAID. For ALL of the disputed dates of service in this fee dispute, the carrier NEVER sent EOBs. Both the collections staff and Dr. VanderWerff called the carrier repeatedly to perform verbal Requests For Reconsideration in accordance with §133.250(e), and both the collections staff AND Dr. VanderWerff were told by bill review that all of these bills were recommended for payment and were only awaiting the adjuster's release. THEN both Dr. VanderWerff and his collections staff were told by both Debbie Eggebraaten as well as Cassandra Grissom (the two previous adjusters handling this claim) that these bills WOULD be paid."

**Amount in Dispute:** \$11,200.00

### Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed. We will provide a supplemental response once the bill auditing company has finalized their review."

**Response Submitted by:** Gallagher Bassett

## Findings and Decision

### Authority

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

### Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.230 sets out the reimbursement guidelines for return-to-work rehabilitation programs.

### Denial Reasons

Neither the requestor nor the respondent submitted EOBs with the DWC060 request.

### Issues

1. Did the requestor submit a bill with a valid state license number?
2. Did the Insurance Carrier take final action on the disputed medical bills?
3. Did the Respondent submit a supplemental response?
4. Is the Requestor entitled to reimbursement?

### Findings

1. The requestor seeks reimbursement for medical services rendered on April 19, 2021 through June 9, 2021.

28 Texas Administrative Code (TAC) §42.20 states, "(a-b) Licensed Doctor of Medicine, osteopathy, chiropractic, and podiatry may act as treating doctors for injured workers entitled to benefits under the Act. (b) Treating doctors may prescribe treatment to be rendered by other persons licensed to provide health care, or by persons not licensed to provide health care who work under the direct supervision and control of the treating."

The DWC issued a cease-and-desist order dated December 21, 2020, which states in part, "It is ordered that Eric A. Vanderwerff, D.C., must immediately cease and desist from the following: Providing health care services in the Texas workers' compensation system, including serving as a treating doctor, until he notifies DWC that the Texas Board of Chiropractic Examiners has allowed him to practice chiropractic medicine."

In addition, the cease-and-desist order states "On October 1, 2020, Dr. Vanderwerff's license expired and remains expired as of December 18, 2020."

The DWC finds that the disputed dates of service were rendered by Karen Austin, D.C., and Christopher Blair, D.C.

2. The requestor seeks reimbursement for CPT Code 97799-CP rendered on April 19, 2021 through June 9, 2021. No EOBs were submitted with the DWC060 request. It is the duty of the workers' compensation insurance carrier **or an agent acting on the insurance carrier's behalf** to pay, reduce, or deny a complete medical bill within 45 days from receiving the bill. The 45-day deadline to make or deny payment is not extended as a result of an audit under 28 TAC §133.230 or as a result of a pending request for additional documentation.

Further, the insurance carrier **must** notify the health care provider of its final action by issuing an explanation of benefits (EOB) and must include on its EOB any bill reductions, denial reasons, and defenses in the form and manner required under 28 TAC §133.240.

Under 28 TAC §133.307, DWC only reviews those denial reasons and defenses presented by the insurance carrier to the health care provider before the date the request for MFDR was filed. Any denial reasons or defenses the insurance carrier raises after the filing of the dispute are not considered in the review of the medical fee dispute. The DWC finds that the disputed charges are eligible for review.

Review of the medical documentation for the disputed dates of service supports the billing and documentation of a chronic pain management program. As a result, the requestor is entitled to reimbursement for the disputed dates of service.

3. The requestor seeks reimbursement for CPT Code 97799-CP-GP rendered on April 19, 2021 through June 9, 2021. The disputed services were rendered by Karen Austin, D.C., and Christopher Blair, D.C.

The insurance carrier states, "...we have escalated the bills in question for manual review to determine if additional monies are owed. We will **provide** a supplemental response once the bill auditing company has finalized their review."

The DWC finds that the insurance carrier did not submit a supplemental response. As a result, a decision is based on the information available at the time of the review.

4. The fee guideline for chronic pain management services is found in 28 TAC §134.230.

28 TAC §134.230(1) states "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

The requestor billed 97799-CP; therefore, the disputed program is Not CARF accredited, and reimbursement shall be 80% of the MAR.

28 TAC §134.230(5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the unit's column on the bill. CARF accredited programs shall add "CA" as a second modifier. (B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

The requestor seeks reimbursement in the amount of \$11,200.00. Reimbursement is recommended as follows:

DOS	CPT CODE	# UNITS	AMT SOUGHT	AMT PAID BY IC	MAR \$100/UNIT	AMOUNT DUE
4/19/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
4/20/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
4/22/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/3/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/6/21	97799-CP	4	\$400.00	\$0.00	\$400.00	\$400.00
5/10/21	97799-CP	4	\$400.00	\$0.00	\$400.00	\$400.00
5/13/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/17/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/18/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/19/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/20/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/24/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/25/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/26/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
5/27/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
6/1/21	97799-CP	4	\$400.00	\$0.00	\$400.00	\$400.00
6/3/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
6/7/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
6/8/21	97799-CP	6	\$600.00	\$0.00	\$600.00	\$600.00
6/9/21	97799-CP	4	\$400.00	\$0.00	\$400.00	\$400.00
Totals			\$11,200.00	\$0.00	\$11,200.00	\$11,200.00

The DWC finds that the requestor has established that a total reimbursement in the amount of \$11,200.00 is due.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds the requester has established that reimbursement of \$11,200.00 is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor \$11,200.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

**Authorized Signature**

		July 22, 2022
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).