



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Millennium Chiropractic

Respondent Name

Texas Association of Counties Risk Management Pool

MFDR Tracking Number

M4-23-2524-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

May 31, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 19, 2022	97799-CP	\$400.00	\$0.00
September 20, 2022	97799-CP	\$400.00	\$0.00
September 26, 2022	97799-CP	\$400.00	\$0.00
September 27, 2022	97799-CP	\$300.00	\$0.00
November 7, 2022	97799-CP	\$500.00	\$0.00
November 8, 2022	97799-CP	\$300.00	\$0.00
November 30, 2022	97799-CP	\$600.00	\$0.00
Total		\$2,900.00	\$0.00

Requestor's Position

"The services rendered on the above disputed dates of service were pre-authorized by the carrier (see attached pre-authorization letters), and were performed and billed in accordance with the ODG and Medical Fee Guideline, and MUST BE PAID."

Amount in Dispute: \$2,900.00

Respondent's Position

"This dispute concerns services provided by Millenium Chiropractic from September 19 to November 30, 2022, totaling \$2,900.00... Dates of Service September 19, 2022 and September 20, 2022 were processed and approved for payment on October 5, 2022 in the amount of \$800.00.

Dates of Service September 26, 2022 and September 27, 2022 were processed and approved for payment on October 7, 2022 in the amount of \$700.00.

Dates of Service November 7, 2022, November 8, 2022, and November 30, 2022 were processed and approved for payment on June 1, 2023 in the amount of \$1400.00.

To aid in your review of this matter, TAC RMP is providing EOBs associated with the disputed date of service."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

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 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.230](#) sets out the fee guideline for return-to-work rehabilitation programs.

Denial Reasons

The insurance carrier issued payment to the requestor after the submission of the DWC060. Although EOBs with recommended payment were presented by the insurance carrier, they did not contain claim adjustment codes.

Issues

1. Did the Insurance Carrier issue payment for the disputed services rendered on September 19 to November 30, 2022?
2. Is the Requestor entitled to additional reimbursement?

Findings

1. The requestor is asking for payment for non-CARF-accredited chronic pain management services that were rendered to the injured worker between September 19, 2022, and November 30, 2022. The insurance company supplied copies of the EOBs to support the payments that were issued following the submission of the MDR request. The DWC will now calculate the reimbursement for the disputed services in order to determine whether the insurance carrier paid in compliance with 28 TAC §134.230(5).

28 TAC §134.230 (5) states, "(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs... (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."

28 TAC §134.230 (1)(B)) which states, "(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."

DOS	CPT/Modifier	Amount Billed	Amount in Dispute	Amount Paid	# of Units	80% MAR \$100/hr.	Amount Due
9/19/2022	97799-CP	\$400.00	\$400.00	\$400.00	4	\$100 x 4 = \$400	\$0.00
9/20/2022	97799-CP	\$400.00	\$400.00	\$400.00	4	\$100 x 4 = \$400	\$0.00
9/26/2022	97799-CP	\$400.00	\$400.00	\$400.00	4	\$100 x 4 = \$400	\$0.00
9/27/2022	97799-CP	\$300.00	\$300.00	\$300.00	3	\$100 x 3 = \$300	\$0.00
11/7/2022	97799-CP	\$500.00	\$500.00	\$500.00	5	\$100 x 5 = \$500	\$0.00
11/8/2022	97799-CP	\$300.00	\$300.00	\$300.00	3	\$100 x 3 = \$300	\$0.00
11/30/2022	97799-CP	\$600.00	\$600.00	\$600.00	6	\$100 x 6 = \$600	\$0.00
Total		\$2,900	\$2,900	\$2,900	29	\$2,900	\$0.00

A review of the Explanation of Benefits (EOBs) provided by the insurance carrier supports that payments totaling \$2,900.00 were issued to the requestor. The following documents the electronic payments:

September 19 and September 20, 2022,

- Electronic Funds Transfer 2317659
- Amount Paid \$800.00
- Date of payment: October 11, 2022

September 26 and September 27, 2022

- Electronic Funds Transfer 2317659
- Amount Paid \$700.00
- Date of payment: October 11, 2022

November 7, November 8, and November 30, 2022

- Electronic Funds Transfer 2336425
- Amount Paid \$1,400.00
- Date of payment: June 2, 2023

2. The requestor is asking for reimbursement in the amount of \$2,900.00 for the disputed services. The insurance carrier paid the requestor the sought amount of \$2,900.00, as a result, the requestor is not entitled to additional reimbursement.

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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

Authorized Signature

		December 21, 2023
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. 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.

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.