TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Millennium Chiropractic

Respondent Name
National Liability & Fire Insurance

MFDR Tracking Number
M4-23-2793-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
June 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13, 2022, through June 28, 2022	97799-CP	$6,225.00	$0.00
June 29, 2022, through December 1, 2022	97799-CP	$17,375.00	$0.00
August 25, 2022	97750-FC	$655.32	$569.82
October 26, 2022	99215	$325.00	$0.00
	Total	$24,580.32	$569.82

Requestor's Position

"The 97799-CP services rendered on the above dates of service were pre-authorized by the carrier (see enclosed pre-authorization approval letters) and were performed and billed in accordance with the ODG and 1996 Medical Fee Guideline and MUST BE PAID IN FULL."

Amount in Dispute: $24,580.32

Supplemental Response dated August 24, 2023

"Please see attached the Proof Of Mailing documents related to the above-mentioned dates of service, viz: 08/02/22, 08/25/22, 08/30/22, 08/31/22 and 09/01/22."

Respondent's Position

"In support of its position that GROUP A bills were previously fully paid, that GROUP B bills not timely received, and GROUP C bills have now been fully paid, the Carrier submits **Exhibit 1**, the relevant bills received by the Carrier and EOBs issued on those bills; and **Exhibit 2**, the Carrier's payment ledger confirming payment has issued as stated hereinabove."

Response Submitted by: Shanley Price

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 §133.20 sets out the medical bill submission procedures for health care providers.
3. 28 TAC §134.225 sets out the fee guidelines for functional capacity evaluations.
4. 28 TAC §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code (TLC) §408.027 sets out the rules for timely submission of claims by health care providers.
6. TLC §408.0272 provides for certain exceptions to untimely submission of a medical bill.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 790 – This charge was reimbursed in accordance with the Texas medical fee guideline.
- 95 – Plan procedures not followed.
- 16 – Claim/service lacks information or has submission/billing error(s).
- DO8 – Supporting medical documentation has not been provided (please resubmit the bill along with the required medical documentation.)
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 320 – Non-accredited interdisciplinary program. Payment reduced 20% below MAR or 20% below usual and customary.
- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment polices.
- U03 – The billed service was reviewed by UR and authorized.

- U05 – The billed service exceeds the UR amount authorized.
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350 – Bill has been identified as a request for reconsideration or appeal.
- Note: Note: Bill is being denied for not being submitted timely Time limit for filing claim/bill has expired.

Issues

1. Has the requestor waived their right to medical fee dispute resolution for dates of service June 13, 2022, through June 28, 2022?
2. Did the insurance carrier submit proof of payment for dates of service rendered on June 29, 2022, to December 1, 2022?
3. Is the insurance carrier's 95-day timely filing denial supported?
4. Is the requestor entitled to reimbursement for CPT Code 97750-FC rendered on August 25, 2022?
5. Is the requestor entitled to reimbursement for CPT Code 99215 rendered on October 26, 2022?

Findings

1. The requestor seeks payment for chronic pain management services, billed under CPT Code 97799-CP from June 13, 2022, to December 1, 2022. The DWC received the request for medical fee dispute resolution on June 30th, 2023. This date is more than a year for dates of service June 13, 2022, to June 28, 2022.

   28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

   28 TAC §133.307 (c) (1) (A) states, "A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   A review of the submitted documentation finds that the disputed services do not involve issues identified in 28 TAC §133.307 (c) (1) (B). The DWC concludes that the requestor has failed to timely file dates of service June 13, 2022, through June 28, 2022, and therefore these dates are not eligible for review.

2. A review of the submitted documentation finds that the insurance carrier issued payments for non-CARF accredited chronic pain management services, billed under CPT code 97799-CP for the dates of service in the below table.

DOS	Billed Amount	Amount in dispute	Paid prior to MDR	Additional Payments	Date Paid	Amount Due
June 29	$800	$775	$25	$775	1/13/23	$0.00
July 6	$400	$400	$0.00	$400	2/14/23	$0.00
July 25	$400	$400	$0.00	$400	1/13/23	$0.00
July 26	$400	$400	$0.00	$400	1/13/23	$0.00
July 28	$400	$400	$0.00	$400	1/18/23	$0.00
August 15	$600	$600	$0.00	$600	1/18/23	$0.00
August 16	$400	$400	$0.00	$400	1/18/23	$0.00
August 17	$600	$600	$0.00	$600	1/18/23	$0.00
August 18	$400	$400	$0.00	$400	1/18/23	$0.00
August 23	$600	$600	$0.00	$600	1/18/23	$0.00
August 24	$400	$400	$0.00	$400	1/18/23	$0.00
August 25	$600	$600	$0.00	$600	1/18/23	$0.00
November29	$400	$400	$0.00	$400	2/14/23	$0.00
September20	$400	$400	$0.00	$400	7/10/23	$0.00
September22	$600	$600	$0.00	$600	7/10/23	$0.00
September26	$400	$400	$0.00	$400	7/10/23	$0.00
September27	$600	$600	$0.00	$600	7/10/23	$0.00
September28	$600	$600	$0.00	$600	7/10/23	$0.00
September29	$600	$600	$0.00	$600	7/10/23	$0.00
October 5	$800	$800	$0.00	$800	7/10/23	$0.00
October 6	$600	$600	$0.00	$600	7/10/23	$0.00
October10	$400	$400	$0.00	$400	7/10/23	$0.00
October11	$400	$400	$0.00	$400	7/10/23	$0.00
October12	$600	$600	$0.00	$600	7/10/23	$0.00
October17	$400	$400	$0.00	$400	7/10/23	$0.00
October18	$600	$600	$0.00	$600	7/10/23	$0.00
October19	$600	$600	$0.00	$600	7/11/23	$0.00
October20	$400	$400	$0.00	$400	7/11/23	$0.00
November 30	$600	$400	$0.00	$600	2/14/23	$0.00
December 1	$600	$400	$0.00	$600	2/14/23	$0.00

From June 29, 2022, to December 1, 2022, the insurance carrier paid the amount billed for the chronic pain management services on each date of service in dispute except for dates of service August 2, 2022, August 30, 2022, August 31, 2022, and September 1, 2022. Therefore, it is recommended that no further payment be made for these service dates.

3. The requestor seeks reimbursement for chronic pain management services rendered on August 2, 2022, August 30, 2022, August 31, 2022, and September 1, 2022. The insurance carrier denied the disputed services due to 95-day timely filing has expired.

   28 TAC §133.20(b) requires that, except as provided in TLC §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in TLC §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not-later than 95 days after the date the disputed services were provided.

   TLC §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 TAC §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   In a supplemental response, the requestor provided supporting documents for their claim that the disputed services were submitted within the 95-day timely filing requirements. Two copies of an envelope made up the documentation that was originally attached to the DWC060 submission and was now included with the supplemental response. A handwritten note indicating the following was found in one of the envelopes, which had a postage date of August 4, 2022, addressed to National Liability and Fire Insurance and included the following information: M.Z. 1440-1, DOS: 8/2/22, Pgs: 2. Another envelope, dated September 2, 2022, was addressed to National Liability and Fire Insurance and included the following information: M.Z. 1550-1, DOS: 8/25, 8/30, 8/31 + 9/1/22, Pgs: 15. Upon reviewing the submitted documents, it is determined that inadequate information is submitted for determining if the disputed medical bills were submitted within 95 days of the services being provided.

   Pursuant to TLC §408.027(a), the requestor has forfeited the right to reimbursement for dates of service August 2, 2022, August 30, 2022, August 31, 2022, and September 1, 2022.

4. The requestor seeks reimbursement for CPT Code 97750-FC x 12 units rendered on August 25, 2022. The insurance carrier audited the disputed service and denied the FCE with reduction codes, 350 and W3. The requestor seeks reimbursement in the amount of $655.32, however, a review of the medical bills and EOBs finds that the requestor billed the insurance carrier the amount of $600.00, as a result this amount is considered in this review.

   CPT Code 97750-FC represents a functional capacity evaluation, subject to the requirements of 28 TAC §134.225, which states in relevant part, "The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test unless it is the initial test. Documentation is required."

   A review of the medical documentation finds that the requestor documented and billed for 12 units of a functional capacity evaluation. The DWC finds that the requestor is therefore entitled to reimbursement for the disputed service.

   The fee guideline for FCEs is found at 28 TAC §134.225.

   28 TAC §134.225 states:

   > The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test unless it is the initial test. Documentation is required. "

   28 TAC §134.203(c)(1) states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83."

   28 TAC §134.203(c)(2) states "The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. The subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment..."

On the disputed dates of service, the requestor billed CPT code 97550-FC (x 12 units). The multiple procedure rule discounting applies to the disputed service.

Medicare Claims Processing Manual Chapter 5, 10.3.7-effective June 6, 2016, titled *Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services*, states:

> Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the ASC X12 837 professional claim format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (ASC X12 837 institutional claim format or Form CMS-1450).
>
> For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.
>
> To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services.
>
> When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The *MPPR Rate File* that contains the payments for 2022 services is found at https://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

- MPPR rates are published by carrier and locality.
- Review of Box 32 on the CMS-1500 finds that the services were rendered in zip code 75061; the Medicare locality is "Dallas."
- The Medicare participating amount for CPT code 97750 at this locality is $34.77 for the first unit, and $25.54 for each subsequent 11 units.
- The DWC conversion factor for 2022 is 62.46.
- The Medicare conversion factor for 2022 is 34.6062.
- The MAR for the first unit is $62.76, and $46.10 for each subsequent unit, for a total of $569.82.
- The requestor is entitled to reimbursement in the amount of $569.82.

5. The requestor seeks reimbursement for CPT Code 99215 rendered on October 26, 2022. A review of the documentation finds that the requestor did not include copies of the medical bills and EOBs for the disputed CPT code.

   Pursuant to 28 TAC §133.307, (c) Requests. Requests for MFDR must be legible and filed in the form and manner prescribed by the division… (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include… (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills); (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   Because the requestor did not submit sufficient documentation to support the disputed service was submitted to the insurance carrier prior to the submission of the MDR, the DWC finds that the disputed service is not eligible for review. As a result, $0.00 is recommended.

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 $569.82 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed service. It is ordered that the Respondent must remit to the Requestor $569.82 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		March 13, 2024
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.