TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Millennium Chiropractic

Respondent Name

Carrollton Farmers Branch ISD

MFDR Tracking Number

M4-26-1931-01

Insurance Carrier's Austin Representative

BOX 17 Downs Stanford PC

DWC Date Received

March 10, 2026

Summary of Findings

Date(s) of Service	Disputed Services	Amount in Dispute	Amount Due
March 10, 2025	98940	$50.00	$0.00
March 10, 2025	97110-GP	$420.48	$397.06
March 10, 2025	97140-59-GP	$98.40	$90.52
March 10, 2025	G0283-GP	$24.00	$20.09
March 10, 2025	97112-GP	$54.81	$0.00
March 11, 2025	97110-GP	$118.89	$95.47
March 11, 2025	97140-GP	$7.88	$0.00
March 11, 2025	G0283-GP	$3.91	$0.00
March 11, 2025	97112-GP	$54.81	$0.00
	Total	$833.18	$603.14

Requester's Position

"ALL services rendered on the above dates of service, including the number of units for each procedure, were pre-authorized by the carrier (see enclosed pre-authorization letter), and were performed and billed in accordance with the ODG and Medical Fee Guideline, and MUST BE PAID".

Amount In Dispute: $833.18

Respondent's Position

The Austin carrier representative for Carrolton Farmers Branch ISD, is Downs Stanford, PC. The representative was notified of this medical fee dispute on March 12, 2026. 28 TAC Section 133.307(d)(1) provides that if the Division does not receive a response within 14 calendar days of the dispute notification, it may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. Accordingly, this decision is based on the available information pursuant to 28 TAC Section 133.307(d)(1).

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section 133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section 134.203 sets out the fee guideline for professional medical services.

Adjustment Reasons

The insurance carrier reduced and denied the disputed charges with the following adjustment reason codes:

1. BT100 – Unless otherwise specified, services have been reviewed to the State Fee Schedule.
2. TXP12 – Workers' compensation jurisdictional fee schedule adjustment.
3. BT180, BT181 – NCCI medically unlikely edits (MUE) rule applied.
4. BT182 – Modifier overrides NCCI procedure to procedure (PTP) rule.
5. BT604 – Physical medicine multiple procedure payment reduction (MPPR) rule applied.
6. TX59 – Processed based on multiple or concurrent procedure rules.

Issues

1. What is DWC considering in this medical fee dispute?
2. What are the denial reasons raised by the insurance carrier during the medical bill review process?
3. What rules apply to the reimbursement of the disputed services?
4. Do any National Correct Coding Initiative (NCCI) edits apply to the disputed services that would affect reimbursement?
5. Is the requester entitled to reimbursement?

Findings

1. The requester seeks reimbursement in the amount of $833.18 for services rendered on March 10 and March 11, 2025, consisting of spinal chiropractic manipulative treatment (CPT 98940), therapeutic exercise (CPT 97110-GP), manual therapy (CPT 97140-GP), neuromuscular reeducation (97112-GP), and electrical stimulation (HCPCS G0283-GP).

   The disputed services were audited and denied by the insurance carrier based on the specified denial codes referenced above. Reimbursement for these services is governed by 28 Texas Administrative Code (TAC) Section 134.203, which mandates the use of Medicare payment policies for coding, billing, reporting, and reimbursement within the Texas Workers' Compensation system.

   Pursuant to 28 TAC Section 134.203(a)(5), "Medicare payment policies" refer to methodologies and coding policies set by the Centers for Medicare and Medicaid Services (CMS). The service in dispute identified above, are evaluated using these standards.

2. A review of the documentation provided by the requester indicates that the insurance carrier denied the disputed services on the basis that the associated codes are subject to payment adjustments driven by billing guidelines, primarily including NCCI edits, multiple-procedure reductions, and workers' compensation fee schedule rules.

   The insurance carrier issued partial payments for services rendered on March 11, 2025, for CPT codes 97110-GP, 97140-59-GP, and G0283-GP. No payment was issued for services rendered on March 10, 2025, or for CPT code 97112-GP provided on March 11, 2025. The division will assess whether the insurance carriers denial reasons are supported.

3. The requester seeks reimbursement for physical therapy and chiropractic rehabilitative services provided on March 10, and March 11, 2025. The requester appended modifier "GP" indicating a physical therapy plan of care.

   Per Medicare Claims Processing Manual Chapter 5, Section 10.7, MPPR applies to "always therapy" services. This section identifies specific CPT/HCPCS codes that are inherently considered therapy services, meaning they are **always subject to Medicare's therapy policies,** regardless of the provider type or setting in which they are performed.

- The requirement to append the appropriate therapy modifier (e.g., GP, GO, or GN)
- Application of therapy billing rules, including plan of care and documentation requirements
- Use of therapy-specific payment methodologies and limitations

The disputed CPT codes, 97112 (neuromuscular reeducation), 97110 (therapeutic exercise), G0283 electrical stimulation, and 97140 (manual therapy) fall under this category, which is why they must be billed with a therapy modifier (like GP) when provided under a physical therapy plan of care.

The rule stipulates full payment for the procedure with the highest practice expense relative value unit (RVU), and 50% payment for subsequent services on the same date of service.

MPPR applies to the disputed CPT codes. Reimbursement must follow the payment methodology pursuant to 28 TAC Section 134.203.

4. To determine whether the insurance carrier's payment adjustments and denials reasons, primarily NCCI edits multiple-procedure reductions, and workers' compensation fee schedule rules, the division conducted NCCI edits for the CPT codes billed on the disputed services.

   A review of the medical bills finds that the requester billed CPT codes 98940, 97110, 97140, G0283, and 97112 on March 10, 2025 and CPT codes 98940, 97110, 97140, G0283, and 97112 on March 11, 2025.

   The following was identified

   - Per Medicare CCI Guidelines, procedure code 97112 has an unbundle relationship with history procedure code 98940. Review of the documentation to determine if a modifier is appropriate finds no modifier was appended. Since no modifier to override the edit was appended, reimbursement for this code is therefore not recommended.

   - No edit conflicts were identified for CPT codes 97110, 97140 and G0283. Reimbursement is recommended and determined pursuant to 28 TAC Section 134.203.

   - For CPT Code 98940, per CMS Billing and Coding: Chiropractic Services, Article A56273, R8 states, "For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. Under **Utilization Guidelines** removed statement: Payment is to the billing chiropractor and is based on the physician fee schedule and added statement: Claims should be filed by the performing chiropractor. The Physician Fee Schedule is used when paying for chiropractor services".

     The "AT" modifier is what tells Medicare that the service is intended as active/corrective treatment.

This comes from CMS guidance (including MLN Matters SE1602 and related billing policy):

- CPT codes **98940, 98941, 98942** are only payable when they are **manual manipulation of the spine to correct a subluxation**
- The **AT modifier** must be appended when the visit is for **active/corrective treatment**
- Without the AT modifier, Medicare assumes maintenance care and denies the claim

The requester did not append modifier "AT" to the disputed CPT code 98940, and CPT Code 98940 was not included in the preauthorization approval issued by IMO, dated March 6, 2025. Reimbursement for this code is not recommended.

5. The Division finds that the requester is entitled to reimbursement for the following services:

   Physical therapy services: CPT codes 97110, 97140 and G0283

   Per 28 TAC Section 134.203(c)(1), the formula to calculate the Maximum Allowable Reimbursement (MAR) is:

   Formula: (DWC CF ÷ Medicare CF) × Medicare Payment = MAR

   - DWC CF (2025): 70.18
   - Medicare CF (2025): 32.3465
   - Locality: Dallas (Zip 75061 / Locality 11)
   - DOS: March 10–11, 2025

   The following CPT codes were considered for payment:

   CPT 97110 – Therapeutic Exercise (8 units)

   - Total MAR: $397.06
   - Billed: $420.48

   DOS Breakdown:

   - 3/10/25: Paid $0.00; recommended reimbursement is $397.06
   - 3/11/25: Paid $301.59; recommended reimbursement is $95.47

   CPT 97140 – Manual Therapy (2 units)

   - Total MAR: $90.52
   - Billed: $98.40

   DOS Breakdown:

   - 03/10/25: Paid $0.00; recommended reimbursement is $90.52
   - 03/11/25: Paid $90.52; recommended additional reimbursement is $0.00

CPT G0283 – Electrical Stimulation

- MAR per unit: $20.09
- Billed: $24.00

DOS Breakdown:

- 3/10/25: Paid $0.00; recommended reimbursement is $20.09
- 3/11/25: Paid $20.09; recommended reimbursement is $0.00

Overall Summary

- Total MAR (Recommended): $603.14

The Division finds that the requester is not entitled to reimbursement for CPT code 98940 (date of service March 10, 2025) and CPT code 97112 (dates of service March 10–11, 2025). However, the requester is entitled to reimbursement for CPT codes 97110-GP, 97140-GP, and G0283-GP in the total MAR amount of $603.14**,** which is the recommended payment amount.

Conclusion

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

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code Sections 413.031 and 413.019, DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Carrollton Farmers Branch ISD must remit to Millennium Chiropractic $603.14 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section 134.130.

Authorized Signature

		May 29, 2026
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 Section 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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section 141.1(d).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.